City of Atlanta

Active Employee Benefits Program
September 2009 – August 2010

EMPLOYEE SELF SERVICE
YOU CAN NOW ENROLL ONLINE

Health Plans * Dental Plans
Life and Vision Plan * Contracted Vendors
Rate Structure * Dependent Eligibility Chart

OPEN ENROLLMENT CAN NOW BE DONE ONLINE!

OPEN ENROLLMENT OVERVIEW

*This year's Open Enrollment Period is **July 6th – July 22nd** for all active and retired City of Atlanta employees. We consider this Open Enrollment as a passive enrollment period, which means that no significant changes were made to the Medical, Dental and Vision Plans. However, the Life Insurance carrier has changed. The new provider is Greater Georgia Life. Please see the enrollment guide for plan details.*

*The option that you select will be effective September 1, 2009 and remain in effect until August 31, 2010, unless you have a qualifying life event. If you **do not** wish to make changes for the new benefit plan year, you are not required to return an application. However, if you need to continue coverage for dependents (19-26) years of age who are Full-Time students, please use the Life Event Change Form and attach documentation. If you would like to make changes to your benefit selections, please submit the enclosed application with the appropriate documentation. All Open Enrollment Applications with benefit changes are due to the Department of Human Resources (DHR) Insurance Division no later than July 22, 2009. If you are completing the application online, Open Enrollment will close at 11:59 p.m. July 22, 2009.*

THIS BOOK IS NOT A CONTRACT

This book provides a summary of benefits available to City of Atlanta employees and their eligible dependents, as well as the procedures to be followed to obtain these benefits. However, if inconsistencies occur between the contents of this book and the contracts, rules or laws regulating administration of the various plans, please understand that the terms set forth in each plan must be followed. In some instances, limitations and exclusions may apply. The DHR Insurance Division has made great efforts to provide accurate and up-to-date information to the best of our ability for City of Atlanta employees and their dependents within this document. However, no rights or benefits will be provided in the event of any error or omission. Furthermore, the City takes no responsibility for third - party information.

Should you have questions or if you are uncertain about your benefits, call the plan representative or the DHR Insurance Division at (404) 330-6036 for assistance.

PLEASE NOTE: Unmarried children who are full-time students between the ages of 19 and 26 are insurable, even if they were not insured prior to age 19. When first insuring them you must provide a birth certificate showing a parent-child relationship with the employee and/or spouse, plus a statement from the school registrar's office or verification from www.studentclearinghouse.org showing full-time student status (small fee may apply). Full-time student status **MUST** be confirmed annually, at a minimum.

A dependent child who returns to full-time student status during the contract year is eligible to be covered provided the **Full-Time Student Statement** and **Change Form** are submitted **within 31 days** of the start of such change in status.

CITY OF ATLANTA OFFICIALS

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***See back (insert) for application and instruct**

COVERAGE CHANGES
09/01/2009 - 08/31/2010

Overall, the plans offered to active employees have not changed, but instead have been slightly enhanced.

Kaiser Permanente . . . . . **No changes**

Blue Cross/Blue Shield of Georgia . . . . . **No changes**

Greater Georgia Life . . . . . **Newborns (birth - 6 months) - $600.00**
First Responder added benefit for line of duty claim at 50% of Base Salary

OptumHealth Vision . . . . . **Rate reduction**
(formerly Spectera Vision)

CIGNA Dental . . . . . **Adult orthodontics**

Humana (CompBenefits) Dental/DHMO . . . **No changes**

AFLAC . . . . . **URM maximum increase to $5,000.00**

Open Enrollment Period — July 6, 2009 - July 22, 2009

BENEFITS HIGHLIGHTS

PROVIDERS	OPTIONS
HEALTH INSURANCE	***OPTIONS (2)***
Blue Cross/Blue Shield of Georgia **(800) 368-0766** www.bcbsga.com	POS
Kaiser Permanente **(404) 261-2590** or **(888) 865-5813** www.kp.org	HMO
DENTAL INSURANCE	***OPTIONS (4)***
CIGNA **(800) CIGNA24** or **(800) 244-6224** www.mycigna.com	High Option Low Option
Humana (CompBenefits) **(800) 342-5209** www.compbenefits.com	Dental Access Dental DHMO
VISION	
OptumHealth Vision **(800) 638-3120** *(formerly Spectera Vision)* www.myoptumhealth.com	
LIFE INSURANCE	
Greater Georgia Life Insurance Company Administrator **(800) 851-8544** Claims **(800) 552-2137**	1 X Salary Plan Salary & Supplemental Life Insurance Dependent Life Insurance Plan
FLEXIBLE SPENDING ACCOUNTS & SUPPLEMENTAL INSURANCE	
AFLAC **(770) 449-5215**	
DEFERRED COMPENSATION	
ING Life Insurance and Annuity Company **(800) 525-4225** Press 1 for Customer Service ingretirementplans.com	
ICMA Retirement Corporation **(800) 669-7400** icmarc.org	
Nationwide Retirement Solutions Plan Admin. **(877) 677-3678** nrsforu.com	
DEFINED CONTRIBUTION RETIREMENT BENEFIT	
ING Life Insurance and Annuity Company **(404) 814-4502**	

HOW TO USE YOUR BENEFITS BOOKLET

Getting the Most From Your Benefits

Revolutionary changes are taking place in the design and implementation of health insurance. This year, the City is offering one Health Maintenance Organization (HMO) and one Point of Service (POS) plan. Because of constant changes and the rising cost of health care, employees need more information regarding insurance benefits in order to deal with the variety of choices you are asked to make. However, becoming knowledgeable and making effective decisions regarding your insurance is not easy. But insurance is important, so the effort is worthwhile. This booklet provides the information necessary to answer health insurance questions, by offering a clear picture of benefits provided by the City of Atlanta for you – the employee. One of the first steps to take is to learn which insurance plans your physician will accept in 2009-2010 and the provisions of each carrier. Once you understand the coverages, you will gain the confidence to take control of your benefits.

Pre-tax Benefits/Payroll Deductions

City of Atlanta employee health/dental benefits are offered on a pre-tax basis through payroll deductions (after-tax basis for Domestic Partners). In some instances, the City will pay a portion of your benefits. Each pay period, the remaining portion will be taken out of your paycheck. This amount will be based upon the carrier and level of coverage you select. For life insurance, deductions are taken from your paycheck once a month.

How to Use This Booklet

This booklet presents basic information about a wide range of options. It is written as a starting point to lay out possibilities for your consideration. It is important that you explore in detail the plans of greatest interest to be sure that you have the up-to-date facts before making a decision. As you read your benefits booklet, you will find guidelines designed to help you analyze your benefits. If you cannot find the answers in this booklet, call your carrier and request additional information. You should try to attend an Open Enrollment Meeting even if you already have coverage with which you are satisfied, you may desire a better understanding of that coverage. This booklet will instruct you how to protect yourself and your family in the event your needs change. It identifies guidelines to use in comparing plans when you are selecting insurance coverage. The benefits booklet also explains how to adjust your coverage to accommodate major life changes such as a new baby, marriage, divorce, children going to college, leaving the City, retirement, and/or the death of a loved one.

However, keep in mind that each section of this booklet should be considered separately, as there is no automatic connection between the sections. Your health and dental insurance providers may be different and most likely will be. Also, your life insurance carrier will differ from both your health and dental insurance carriers.

Health Terms

The list of terms in the *Glossary* section, located in the back of this booklet, may provide helpful insight. Various health-care terms and options are defined and explained, such as “deductibles,” “coinsurance,” “UCR,” and more. These definitions will familiarize you with some of the language of the benefits industry and health insurance providers.

Select Carefully

The information in this booklet offers the information that is essential to become an effective manager of your benefits. After all, who cares more about conserving your resources than you? Choices available are for the financial security of employees and their dependents. Please review your booklet thoroughly and read the directions for completing your 2009-2010 application before making your final selection. Remember, only you are capable of making the decision that best suits your needs.

You DO NOT have to return an application during Open Enrollment UNLESS:

- ***You do not have coverage, and want insurance in the plan year 09/01/2009 - 08/31/2010.***
- ***You want to change carriers.***
- ***You want to add or delete a dependent.***
- ***You are submitting the required full-time student documentation for a dependent child between the ages of 19 - 26. (Failure to submit full-time student documentation will terminate the dependent’s coverage 08/31/2009). Use the form in the Open Enrollment package – no need to return the complete application.***

BENEFITS OVERVIEW

In 2009-2010, the City of Atlanta will offer employees a competitive flexible benefits program, consisting of the following:

Health Insurance

•

Dental Insurance

•

Life Insurance

•

Vision

•

Flexible Spending Accounts

•

Supplemental Insurance – Not Covered Under Group Plan

•

Deferred Compensation Plan

•

Defined Contribution Plan

In 2001, a new ordinance, adopted as amended by Council and approved by then Mayor Bill Campbell, which made available to all full-time city of Atlanta employees **up to (4) four hours** of paid leave per calendar year to undergo **health screening for cardiovascular disease, cancer, HIV, diabetes and pneumonia/influenza**. Employees must submit to their supervisor or appropriate department personnel representative a signed copy of the medical documentation verifying they underwent a health screening for one or more of the above illness or disease processes in order to be granted leave under provisions of this ordinance. Please take advantage of this benefit to make sure you remain healthy and that any health issues are identified.

Benefits Eligibility

Elected officials, appointed officials, full-time and part-time permanent employees and their dependents are eligible to enroll in the City of Atlanta's health and dental plans. Of course, dependents must meet certain eligibility criteria to be considered. The following is a list of eligible dependents:

- A spouse (a husband or wife who is joined in marriage to an employee by a ceremony recognized by the laws of the State of Georgia)
- A domestic partner (registered with the City of Atlanta)
- An unmarried dependent child of an employee (until the end of the benefit year – August 31 – in which the child becomes 19)
- An unmarried child (19 through 26 years of age) who is attending an accredited educational institution on **a full-time basis**. Coverage ends at the end of the month the unmarried child is no longer a student or at the end of the month the child reaches age 26.
- A legally adopted (unmarried) child under age 19, or a child for whom you have guardianship **(permanent or deemed permanent for insurance purposes)**
- A step-child (unmarried) under age 19, permanently residing with the employee and supported by the employee
- A child (unmarried) under age 19, receiving court-ordered support
- A child (unmarried) 19 years or older who is incapable of self-support due to mental or physical disability; and who
  - Has a permanent disability
  - Resides permanently with and is supported by employee.

DEPENDENT ELIGIBILITY DOCUMENTATION REQUIREMENTS

*Copies of the appropriate documents must be attached to your Open Enrollment Application.**

DEPENDENTS	DOCUMENTATION REQUIRED
For Spouse	• Copy of Marriage Certificate. If previously married, death certificate or divorce decree.
For Removal of Spouse/Child	• None at Open Enrollment. Court Decree **within 31 days** of Decree during the contract year.
For Natural Child(ren)	• Child's Birth Certificate (showing a parent-child relationship to employee and/or spouse).
For Adopted Child(ren)	• Placement Papers signed by the Courts.
For Overage Dependent (19-26 yrs of age)	• Statement from registrar of full-time student status from an accredited educational institution or online from www.studentclearinghouse.org at Open Enrollment or **within 31 days** of full-time student status (coverage terminates at the end of month of 26th birthday or graduation).
For Disabled Child (19 yrs and older)	• Physician Verification of permanent disability.
Foreign Adoptions	• Adoption Papers signed by the Courts. • Visa showing date of entry to USA.
For Step Child(ren)	• Child's Birth Certificate (showing parent-child relationship with spouse). • Copy of Marriage Certificate.
For Court-Ordered Support	• State Affidavit. • Copy of signed Court Order requiring employee to provide support for health coverage.
For Guardianship	• Court ordered guardianship deemed permanent for insurance purposes.
For Domestic Partner	• City of Atlanta Affidavit of Financial Reliance (Notarized) **within 31 days** of approval.
For Termination of Domestic Partner	• None at Open Enrollment. City of Atlanta Notice of Termination **within 31 days** of termination during the contract year.

Social Security number and birth date must be provided for all dependents. Failure to submit the dependent's Social Security number will result in termination/denial of coverage (exceptions: newborns age 6 months or less).

Child(ren) must be unmarried.
Documentation also applies to life insurance coverage.
Documentation is not required at Open Enrollment to delete a dependent.

**In most cases, documentation is needed if the employee is adding a dependent, making changes on a dependent's status, or for confirmation of student status.*

If both you and your spouse are insured under a City of Atlanta health/dental plan as an employee or retiree, your children may be insured as dependents of either you or your spouse, for health/dental coverage.

***No city employee/retiree may be the dependent of another employee/retiree for health, vision or dental insurance.** However, for Life Insurance an employee may cover his/her spouse even if the spouse is an employee/retiree. Children may be insured by both parents for life insurance coverage.*

Documentation for full-time students must be submitted <u>within 31 days</u> of the beginning of the school term or returned with your Open Enrollment Application. Please keep a copy of any documentation that you send with your Enrollment Application.

All documentation should contain the employee's name and Social Security number.

Confirmation audits of full-time student status may occur periodically during the coverage year. If full-time student status is not confirmed, coverage may be discontinued.

OPEN ENROLLMENT MEETINGS
Plan Year 09/01/2009 - 08/31/2010

CITY OF ATLANTA
FY-2010 OPEN ENROLLMENT MEETING SCHEDULE
For the Benefit Year beginning September 1, 2009 and ending August 31, 2010

ASSISTANCE FOR SELF SERVE IS AVAILABLE 8:00 AM - 6:00 PM MONDAY 7/06/09 THROUGH THURSDAY 7/22/09

These meetings are the best time to get clarification concerning your benefits. The DHR Insurance Division staff will be available at all meetings and representatives from the carriers will be at most meetings.

WEEK DAY PRESENTATIONS

Thursday, July 9
Civic Center

Monday, July 13
City Hall East Presentation Room

Tuesday, July 14
City Hall Council Chambers

Wednesday, July 15
Civic Center

Presentation from 11:00 a.m. – 3:00 p.m.
Staff Available 10:30 a.m. - 3:00 p.m.

SATURDAY PRESENTATION

Saturday, July 18
Civic Center

Presentation from 11:00 am – 3:00 p.m.
Staff Available 10:30 p.m. - 3:00 p.m.

ENROLLMENT ASSISTANCE FOR SELF SERVE

Monday, July 6
through
Thursday, July 22
City Hall Tower Auditorium

No Formal Presentation
Enrollment Information and Assistance Available

Staff Available 8:00 a.m. - 6:00 p.m.

OPEN ENROLLMENT MEETING LOCATIONS

- ***Atlanta Civic Center***
  395 Piedmont Avenue, N.E. - Piedmont Room*
- ***City Hall Tower Auditorium***
  68 Mitchell St. - 3rd Floor (Old Council Chambers)
- ***City Hall Council Chambers***
  55 Trinity Ave., 2nd Floor
- ***City Hall East Presentation Room***
  675 Ponce de Leon, 1st Floor*
- ***Hartsfield-Jackson Development Program Technical Center***
  1255 South Loop Rd.*
- ***Hartsfield-Jackson Airport Gateway Conference Room***
  4th Floor Atrium - 6000 N. Terminal Parkway

**Free parking available.*

AIRPORT PRESENTATIONS

Friday, July 17
Airport Gateway Conference Room

Presentation at 8:30 a.m.
Staff Available 8:00 a.m. - 11:00 a.m.

Friday, July 17
Airport Technical Center

Presentation at 2:30 p.m.
Staff Available 2:00 p.m. - 4:00 p.m.

Applications for any Employee/Retiree making changes to their insurance coverage are to be entered online or are due back to DHR – Insurance Division *no later than Wednesday, July 22, 2009*. Please read the Open Enrollment materials carefully to determine if you need to submit an application.

OPEN ENROLLMENT INSTRUCTIONS
09/01/2009 - 08/31/2010

Things you may find handy before logging in to "SSHR". Know the Primary Care Physicans name and 10 digit number plus the SSN of new dependents.

ENROLLING INTO YOUR COA BENEFITS USING ORACLE SELF SERVICE

Benefits Open Enrollment can now be done online! There are six main parts to this process and each is outlined in this step by step guide.

1. Access the Oracle www.atlantaga.gov
2. Click on Departments - Human Resources
3. Click on Employee/Retiree Benefits Home Page

Page 1: Dependents and Beneficiaries

This is where you will enter anyone you want to list as a dependent and or beneficiaries if they are not there.

4. Click Add Another Person .
5. Enter the person's **Name and Relationship**.
6. Enter their Address Information, or if they share the same residence as you, check the shared residence box.
7. Enter the Required Information: Student Status should only be entered for children 19 yrs. or older who are currently full-time students.
8. When finished, click Apply .
9. Repeat steps 5-9 as many times as necessary to enter Dependents and beneficiaries.
10. When you are Ready to Continue, click Next .

Page 2: Benefits Enrollments

This page will show an overview of available benefits and your current status. To enroll move to step 11.

11. Click Update Benefits
12. Check the boxes next to the benefits you want to select. You can Add Dependents and Beneficiaries at any time by clicking the button, although you will have to repeat the step you are on once you have added the additional people.
13. When you have made your selections and are Ready to continue, click Next .

Page 3: Update Benefits – Cover Dependents

This is where you will choose which dependents will be covered for your selected benefits.

14. Click on the box next to their name if you want them to be covered under this corresponding benefit.
15. When you have made your selections and are Ready to Continue, click Next .

Page 4: Update Beneficiaries : Add Beneficiaries

This is where you can specify what percentage of any Insurance payouts you want each of your beneficiaries to receive.

16. Choose which beneficiaries would receive anything as a primary recipient (for example, will your spouse receive 100% of the benefit if something happens to you).
17. Choose which beneficiaries would receive anything as a contingent recipient (for example, what will your children receive if something happens to you or your primary recipient)?
18. To recalculate your total, click Recalculate . Both the primary and contingent percentages should equal 100%.
19. Repeat for additional policies listed.
20. When you are ready to continue, click Next .

Page 5: Add Primary Care Providers

21. Depending on the plans you have selected for your medical and dental insurance, you may be asked to enter your primary care provider's ID, name and specialty.
22. When you are ready to continue, click Next .

Page 6: Confirmation Page

This page allows you to review everything you have selected.

- If you want a printable version of this page, click, Printable Page .
- If you want a Confirmation Statement, click Confirmation Statement .

23. When finished, click Finish .

You will then see another review of what you have selected.

If you want to make any changes, click Update Benefits and follow from step 11. You're Done!

Note: You can make changes to updates as changes are accepted throughout the Open Enrollment Period.

OPEN ENROLLMENT INSTRUCTIONS
09/01/2009 - 08/31/2010

You must complete and return an application if you do not enroll using Oracle Self Service and are currently not covered under a City Plan, changing coverage, adding a dependent or are required to provide documentation for a full-time student. Print your *name* and *social security number* on all documents submitted. Telephone numbers are also required and should be listed on your applications. ***Return your Open Enrollment application by July 22, 2009.*** You should contact the carriers to insure your physicians are participating providers in your plan**.**

The Open Enrollment Application is the document employees must use to enroll in health and/or optional dental and/or vision insurance and to decline health and/or dental and/or vision insurance for 09/01/2009 through 08/31/2010. Be sure to initial the choices you elect on your Application Form.

I. EDUCATE YOURSELF ON YOUR BENEFIT PLAN OPTIONS

- Review information in this booklet about each of the health, dental, vision and life plans available to employees
- Call the carrier/HMO if you have questions
- Attend an Open Enrollment Meeting and speak to carrier/HMO representatives
- Contact the DHR Insurance Division **(404) 330-6036** for further information

II. YOU MAY ENROLL ONLINE USING EMPLOYEE SELF SERVICE OR YOU MAY FILL OUT YOUR OPEN ENROLLMENT APPLICATION FORM. An Enrollment Application is included with your Benefits Booklet. Assistance in completion of the application will be available in the City Hall Atrium July 9th, 11th and 16th. Full instructions for completion of the Open Enrollment Application can be found in the back pocket behind your application.

III. IMPORTANT POINTS TO REMEMBER:

- **If you fail to provide the required documentation, your dependent(s) will not be covered.** It is the employee's responsibility to confirm the dependent's coverage. Notifications are not sent to employees who fail to submit the required documentation.
- If you do not provide a registrar's Full-Time Student Statement to continue insurance for children over 19 years of age, the dependent's coverage will end August 31, 2009.
- Your eligible dependents may only be insured with the same insurance carrier/benefit plan you have chosen for yourself.
- Remember to put your name and Social Security number on all documentation and staple the documentation to the application verification form if you are making any changes.
- PLEASE NOTE: You will be able to print confirmation of coverage online.
- Check your payroll statement for the coverage on file with the City and the deduction taken. Notify the DHR Insurance Division or your departmental payroll clerk/HR representative of any discrepancies.

Name and Address Changes

If your name or address has changed, please submit that information to your Payroll Clerk to correct the City of Atlanta records.

Carrier booklets are available from your Payroll Clerk, at the Open Enrollment Meetings or at the DHR Insurance Division, Room 2107, 68 Mitchell St., S.W., Atlanta, GA 30303.

THE FOLLOWING FACTS MAY ANSWER QUESTIONS YOU HAVE CONCERNING YOUR INSURANCE

PLEASE NOTE: You will be sent a Confirmation of Coverage Form if you have changed coverage or provided full-time student documentation prior to 09/01/2009. It will show the coverage you chose, the dependents covered and the premium amount. You will have 14 days to make corrections to your application. Your coverage will be in effect through 08/31/10 except for changes in family status or relocation of the carriers service area.

NO INSURANCE

If you do not want health and/or dental insurance during 09/01/2009 - 08/31/2010, you must initial **NO COVERAGE**.

COVERAGE FOR OVER-AGE DEPENDENT CHILD

To continue coverage for a dependent child between ages 19 and his/her 26th birthday, you must submit a *Full-time Student Statement* from the Registrar's Office of the accredited educational institution where your dependent child is enrolled as a full-time student or online at www.studentclearinghouse.org and attach the statement to the form in your Open Enrollment package. **The insurance carrier/HMO will terminate children over age 19, if a Full-time Student Statement is not submitted during Open Enrollment. Print your name and Social Security number on the statement.** If you wish to cover a child over 19 and under 26, who was not covered July 1, 2008 - August 31, 2009, you must submit documentation showing a parent-child relationship (birth certificate) in addition to the full-time student statement.

COVERAGE FOR MENTAL OR PHYSICALLY DISABLED DEPENDENT

To provide coverage for a dependent who is incapable of self-support because of a mental or physical incapacity, an employee must provide a completed *Physician Verification* of permanent disability. This form is available in the DHR Insurance Division.

CHANGE OF ADDRESS

You must submit a change of address to your payroll clerk or to the Department of Human Resources to correct the City of Atlanta records.

PAYROLL DEDUCTIONS

As an employee, your share of health/dental insurance will be deducted from your paycheck every payday. However, in the case of late Open Enrollments, payroll deductions may be delayed. If this occurs, back premiums and/or refunds (if applicable) will be included in your paycheck as soon as possible.

ID CARDS

After your Open Enrollment Application is processed and an eligibility file is sent to each insurance carrier, your ID card and member booklet will be mailed to your home address by the selected insurance company/HMO. The ID card should be placed in your wallet for easy access at all times. Be sure to read the member booklet carefully, and keep it in a safe place for easy reference. The member booklet will provide detailed information on how to use your insurance benefits. You will not receive a new ID card unless you make a change in your coverage.

Reimbursable claims should be filed only with your insurance carrier, not the City of Atlanta.

NOTE: All members will receive separate cards for dental and vision coverage.

As of September 1, 2009, if you need medical care prior to receiving your new ID card, use a physician and/or hospital on your new Carrier/HMO list of providers.

PLEASE RETAIN THE YELLOW COPY OF YOUR OPEN ENROLLMENT APPLICATION *OR* MAKE A COPY OF YOUR EMPLOYEE SELF SERVICE APPLICATION AND DOCUMENTATION THAT YOU HAVE SUBMITTED FOR YOUR RECORDS. ALWAYS PRINT YOUR NAME AND SOCIAL SECURITY NUMBER ON ALL DOCUMENTATION. MAKE A COPY AND ATTACH IT TO THE ENROLLMENT FORM OR STUDENT VERIFICATION FORM.

Note: HMO and POS ID cards cannot be issued without a Primary Care Physician (PCP).

CHANGES IN COVERAGE

Change In Family Status

You may change your health and/or dental insurance coverage during the open enrollment period. You can also change your coverage during the year but only if the application to change coverage is submitted **within 31 days** of your family status change because of:

- marriage;
- divorce*;
- birth, legal adoption, placement for adoption or custody change of an eligible child;
- death of a spouse or eligible child, or a dependent's leaving the household as a result of a custody agreement;
- changes in the spouse's employment which affects his/her eligibility for benefits under another employer's group benefits plan; or
- a dependent who becomes ineligible as a result of reaching the plan's age limit or is no longer a full-time student.

** Any one removed from the policy is entitled to COBRA (see Continuation of Coverage).*

** Coverage will be effective the date of the Change in Family Status. An adjustment of the premium for the level of coverage change will be deducted from your paycheck.*

Ask your departmental payroll clerk for a **Health Insurance Change Application**. Both you and your spouse (if applicable) must sign the form. Return the form to your departmental payroll clerk.

Option Changes

Option changes are permitted only during the open enrollment period. Changes made during the open enrollment period become effective on September 1, 2009.

If you move out of the service area covered by the HMO in which you are enrolled, you must request a change to another plan **within 31 days** of your move or at the next open enrollment.

If a Plan listed in this brochure ceases operation, during the plan year, employees will have a choice to move to another plan.

If You Are on Workers Compensation or an Authorized Leave of Absence

If you are on Workers Compensation or an Authorized Leave of Absence without pay due to military, maternity, sick, family or study leave, you must pay – in advance – your share of coverage premiums directly to the DHR Insurance Division.

If you are on an Authorized Leave of Absence without pay for any reason **other** than a military, maternity, sick, family or study leave, you may continue your City of Atlanta group insurance by paying – in advance – the total premium (your share and the City's share) directly to the DHR Insurance Division.

If you do not pay the premium on time, your coverage will end.

Termination of Coverage

If your coverage ends for you and your dependents due to termination of employment with the City of Atlanta or change to part-time no benefits status, you can choose to continue coverage for yourself and/or dependents at 102% of the total cost under The City of Atlanta Plan (COBRA) or you may convert to an individual policy.

The HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA), better known as the KASSEBAUM-KENNEDY LEGISLATION states:

If you terminate your employment, cease to be an eligible dependent, or your COBRA eligibility terminates, A CERTIFICATE OF GROUP HEALTH PLAN COVERAGE WILL BE MAILED by your Insurance Carrier/HMO to the last address on their file.

If you do not respond to the confirmation of coverage with changes, you will be enrolled in your current coverage and you will not be allowed to change coverage from 09/01/2008 - 08/31/2009 unless there is a change in family status or you relocate out of the service area of the carrier.

CONSUMER CHOICE OPTION

Effective January 1, 2000, Georgia law required insurers to offer a "Consumer Choice" option to members enrolling in a HMO plan. This option allows members to receive services from a non-network provider (physician, hospital or other provider) while still being covered at an in-network level.

Although you may "nominate" any non-network provider, the nominated doctor or hospital must first agree to the following in order for your services to be covered at the in-network rate:

1. Accept the insurer's reimbursement as payment in full (in addition to the members' usual copayment, deductibles and/or coinsurance).
2. Comply with the insurer's utilization management programs.

After you select the out-of-network provider, you **must** complete a Provider Nomination Form and receive notification from the insurer that the nomination has been accepted before out-of-network providers can be reimbursed at in-network benefit level. For any nominations to be approved, the provider must sign the form agreeing to the insurer's terms and conditions **before** that provider's services will be covered at in-network levels. The provider makes the decision regarding whether he or she will participate in the Consumer Choice Option plan.

The law does not obligate a provider to accept an insurer's terms and conditions or its reimbursement rates. If a provider elects not to sign the Consumer Choice Option Provider Nomination Form, he or she is under no obligation to do so.

If you are seeking services from a specific provider, we recommend that you check with that provider BEFORE completing the Consumer Choice Option application and making a final plan election.

The law allows insurers to increase the monthly premium rate for employees who elect this offering. **The amount of the monthly premium increase over the Kaiser HMO rates is 17.5% for Consumer Choice Option HMO.** Because this amount is billed to the City of Atlanta, your deductions by the City will be higher than the deductions would be if you did not choose this option. You are responsible for the applicable 17.5% increase for HMO as well as the usual employee deduction. You should check with the City's Employee Benefits Department to determine the exact amount to be deducted before you elect a Consumer Choice Option plan.

Selecting the Consumer Choice Option is just like selecting any other benefit option. You must do so either during annual enrollment, when newly hired or when the City's eligibility rules allow you to do so.

You must contact DHR Insurance Division at (404) 330-6036 if you wish to apply for the Consumer Choice Option on your HMO plan.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Portability Provision

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 provides protection for employees and dependents who have pre-existing medical conditions or might be denied health coverage based on factors related to an individual's health. HIPAA includes changes that:

- Limit Exclusion for pre-existing conditions.
- Prohibit discrimination against employees and dependents based on their health status.
- Guarantee renewability and availability of health coverage to certain employers and individuals; and
- Protect many workers who lose health coverage by providing better access to individual health insurance coverage.

Under HIPAA the employer may impose a pre-existing condition exclusion with respect to an employee, dependent or beneficiary only if the following requirements are satisfied:

- A pre-existing condition exclusion must relate to a condition for which medical advice, diagnosis, care or treatment was recommended or received during the 6-month period prior to an individual's enrollment date;
- a pre-existing condition exclusion may not last for more than 12 months after an individual's enrollment date; and
- this 12-month period must be reduced by the length of time of the individual's prior creditable coverage, excluding coverage before any break in coverage of 90 days or more

How Portability Affects City of Atlanta Employees

Effective January 1, 1998, you and your dependents did not have to satisfy a pre-existing condition waiting period if you provide certification of prior creditable coverage sufficient to satisfy the respective pre-existing condition waiting periods.

When Applying for Coverage as a New Employee

As a new employee, you will be subject to the City of Atlanta's pre-existing condition provision unless a certificate of coverage showing prior creditable coverage is provided with the application upon enrollment. The maximum waiting period for pre-existing conditions which may be applied is 12 months. It is your responsibility to obtain the certificate of coverage from your previous coverage and to provide it with the completed enrollment application.

In order for creditable coverage to be applied toward a pre-existing condition waiting period, there can be no more than a 90 day break in coverage.

When an Employee Terminates Coverage

HIPAA requires that your Insurance Carrier/HMO provide you (and your dependents) with certificates of coverage automatically upon termination of coverage.

Special Enrollment Periods

There are special enrollment periods for you and your dependents who:

- originally declined coverage because of other coverage, and
- who exhausted COBRA benefits, lost eligibility for prior coverage, or employer contributions toward coverage were terminated, and
- an individual declining coverage must certify in writing that they are covered by another health program when they initially decline coverage under this group in order to later qualify under this special enrollment. A person declining coverage will be given notice of the consequences when they originally decline coverage.

In addition there are also special enrollment periods for new dependents resulting from marriages, births or adoptions. An unenrolled member may enroll **within 31 days** of such a special qualifying event.

Important Notes

- Individuals enrolled during special enrollment periods are not late enrollees and are subject to the normal pre-existing condition requirements unless enrolled under prior creditable coverage (excluding newborns, adoptions and pregnancies).
- Individual or dependents must request coverage **within 31 days** of qualifying event (i.e. marriages, exhaustion of COBRA, etc.).
- Evidence of prior creditable coverage is required.

Please refer to your benefit booklet for more information concerning Portability Provisions and Requirements.

All new hires should submit a copy of the HIPAA Form received from their previous employer to the DHR Insurance Division for proper credit.

CITY OF ATLANTA 401(a) DEFINED CONTRIBUTION PLAN

The City of Atlanta implemented a mandatory 401(a) Defined Contribution Plan for full-time permanent general employees (does not include sworn police officers and firefighters) hired on or after July 1, 2001.

Effective November 2005, this Plan was amended to exclude full-time permanent general employees hired after that date that are classified (over-time eligible) or pay grade 18 or below. These employees will participate in the City of Atlanta General Employees Defined Benefit Pension Plan.

Employees eligible to participate in the Defined Contribution Plan must complete an enrollment form and make their investment fund selections.

For current Defined Contribution Plan participants seeking transaction assistance and account inquiries, please contact ING at **(800) 584-6001**. For enrollment assistance, including investment education, please call Scott A. Brown at **(404) 814-4502**. Once your account is established, you may also obtain access via the internet at www.ingretirementplans.com.

Upon termination, Defined Contribution Plan participants must contact ING at **(800) 584-6001** to begin the process of Pension Fund withdrawal.

Scott A. Brown
Client Relations Manager
(404) 814-4502 *(Office)*
(404) 814-4545 *(Fax)*
scott.brown@us.ing.com

To access your account online:
www.ingretirementplans.com

BLUECHOICE POS PLAN
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In addition to copayments, members are responsible for deductibles, as described below.
Please review the deductible information to know if a deductible applies to a specific covered service.

Members are also responsible for all costs over the plan maximums.
Plan maximums and other important information appear in *italics*.

Each member enrolling in this plan must list a primary care physician on the enrollment application.
When using out-of-network providers, members are responsible for any difference between the allowed amount and actual charges, as well as any copayments and deductibles.

DEDUCTIBLES, MAXIMUMS, ETC.	IN-NETWORK BENEFIT LEVEL	OUT-OF-NETWORK BENEFIT LEVEL
Calendar Year Deductible: *one for employee, one for spouse, one for all eligible children combined*		
– Individual	None	$300
– Family	None	$900
Coinsurance/Copayments	Plan pays 100%; Member pays copayments as required	Plan pays 70% after deductible; Member pays 30% after deductible
Lifetime Maximum	Unlimited	$1,000,000
Out-of-Pocket Calendar Year Maximum*		
– Individual	None	$2,000
– Family	None	$6,000

**Maximum of three (3) per family* (one for employee, one for spouse and one for all eligible children combined). The following do not apply to out-of-pocket maximum: deductibles, copayment amounts, non-emergency room copayments, non-covered items and coinsurance for behavioral health/substance abuse. Out-of-Pocket limits are accumulated separately for in-network and out-of-network services.

COVERED SERVICES	IN-NETWORK BENEFIT LEVEL	OUT-OF-NETWORK BENEFIT LEVEL
Office Visits: Preventive Care		
• Well-child care, immunizations	$15 copayment	Plan pays 70% after deductible
• Periodic health examinations	$15 copayment	Not covered
• Annual gynecology examination (No PCP referral required – Must use in-network provider for in-network benefits)	$25 copayment	Plan pays 70% after deductible
• Adult Annual Physical	$15 copayment PCP (maximum benefit $500) $25 copayment Specialist (maximum benefit $500)	Plan pays 70% after deductible (maximum benefit $500)
• Prostate screening	$25 copayment	Plan pays 70% after deductible
Illness or Injury		
• Primary Care Physician (PCP) office visit (includes lab, radiology and office surgery)	$15 copayment	Plan pays 70% after deductible
• Primary care physician after hours visit	$25 copayment	Plan pays 70% after deductible
• Specialty care physician office visit (PCP referral required)	$25 copayment	Plan pays 70% after deductible
• Second surgical opinion (PCP referral required)	$25 copayment	Plan pays 70% after deductible
• Allergy care (office visit, testing, serum and allergy shots)	$25 copayment	Plan pays 70% after deductible

BLUECHOICE POS PLAN
BENEFITS SUMMARY 09/01/2009 - 08/31/2010
(cont'd)

COVERED SERVICES	IN-NETWORK BENEFIT LEVEL	OUT-OF-NETWORK BENEFIT LEVEL
• Maternity physician services (prenatal, delivery, postpartum)	$25 copayment at first office visit	Plan pays 70% after deductible
• Vision care services provided by a network ophthalmologist or optometrist for treatment of acute conditions (No PCP referral required)	$25 copayment	Plan pays 70% after deductible
• Services provided by network dermatologists (No PCP referral required)	$25 copayment	Plan pays 70% after deductible
Emergency Room Services		
• Life-threatening illness, serious accidental injury or with a PCP referral	$75 copayment *(waived if admitted)*	$75 copayment *(waived if admitted)*
• Non-emergency use of the emergency room	Not covered	Not covered
Inpatient Services		
• Daily room, board and general nursing care at semi-private room rate; ICU/CCU; other medically necessary hospital charges such as diagnostic x-ray and lab services; newborn nursery care	Per admission copayment $200	Plan pays 70% after deductible
• Physician services (surgeon, anesthesiologist, radiologist, pathologist, etc.)	Plan pays 100% after copayment	Plan pays 70% after deductible
Outpatient Services		
• Surgery facility/hospital charges (outside a physician's office)	Plan pays 100% after $100 copayment	Plan pays 70% after deductible
• Diagnostic X-ray and lab services	Plan pays 100%	Plan pays 70% after deductible
• Physician services (surgeon, anesthesiologist, radiologist, pathologist, etc.)	Plan pays 100%	Plan pays 70% after deductible
Therapy Services	**Calendar year visit limits are combined between in-network and out-of-network**	
• Speech Therapy	$25 copayment; 20-visit calendar year maximum	Plan pays 70% after deductible; 20-visit calendar year maximum
• Physical, occupational therapy	$25 copayment; 20-visit calendar year maximum	Plan pays 70% after deductible; 20-visit calendar year maximum
• Respiratory therapy	Plan pays 100%; 30-visit calendar year maximum	Plan pays 70% after deductible; 30-visit calendar year maximum
• Radiation therapy, chemotherapy	Plan pays 100%	Plan pays 70% after deductible

BLUECHOICE POS PLAN
BENEFITS SUMMARY 09/01/2009 - 08/31/2010
(cont'd)

COVERED SERVICES	IN-NETWORK BENEFIT LEVEL	OUT-OF-NETWORK BENEFIT LEVEL
Mental Health/Substance Abuse	**No Primary Care Physician referral required. Services must be authorized by Blue Cross/Blue Shield of Georgia Behavioral Health at (800) 368-0766**	
• Inpatient (45 days per cal. yr. max.)	$200 copayment; Plan pays 100%	Plan pays 70% after deductible
• Outpatient (max. 40 visits per cal yr.)	$25 copayment; Plan pays 100%	Plan pays 70% after deductible
Other Services		
• Skilled nursing facility (100 days maximum)	$200 copayment; Plan pays 100%	Plan pays 70% after deductible
• Home HealthCare (40 visits per cal. yr. max.)	Plan pays 100%	Plan pays 70% after deductible
• Hospice Care *($7,500 maximum)*	Plan pays 100%	Plan pays 100%
• Ambulance	$100 copayment; Plan pays 100%	Plan pays 70% after deductible
Prescription Drugs		
To receive maximum coverage, have your prescriptions written by a network physician and filled at one of the pharmacies in our network. These include certain local independent pharmacies, as well as many national chain pharmacies: Bi-Lo, CVS, Eckerd, Kmart, Kroger, Publix, Save-Rite, Walgreens, Wal-Mart, Winn-Dixie.	Unless otherwise indicated in the Summary Plan Description, each prescription has a 30-day supply limit. Each mail order maintenance prescription has a 90–day supply limit.	
Retail: 30-day supply		
Generic	$10	Plan pays 70% after the deductible for covered prescriptions at non-participating pharmacies.
Brand Formulary	$25	
Brand Non-Formulary	$40	
Mail order: (Maintenance drugs only)	90-day supply	**NO MAIL ORDER PRESCRIPTIONS ARE AVAILABLE OUT-OF-NETWORK**
Generic	$20	
Brand Formulary	$50	
Brand Non-Formulary	$80	
Vision	The coverage will be limited to one (1) eye examination for corrective lenses per member in a 12 month period, (corrective lenses is intended to include contacts as well as glasses). Office visit co-payment should be the same as for any other specialist $25.00 in-network and 70% of UCR, after the deductible, out-of-network. The City will not cover lenses, frames, disposable or hard contact lenses and POS Members will be encouraged to utilize the BCBS discounted vision program.	

For a full disclosure of all benefits, exclusions and limitations please refer to your Summary Plan Description.

Blue Cross/Blue Shield of Georgia will designate a Primary Care Physician (PCP) for you if you do not list one on your Enrollment Application. You may change your PCP by notifying Blue Cross/Blue Shield of Georgia. If notification is received prior to the 25th, the PCP will change the 1st of the following month. Notification after the 25th will delay the change a month.

BLUECHOICE POS PLAN
BENEFITS SUMMARY 09/01/2009 - 08/31/2010
(cont'd)

Primary Care Physician

A primary care physician, or PCP, is a doctor who specializes in family or general practice, internal medicine or pediatrics and participates in the BlueChoice Option network. Each BlueChoice Option member must select a PCP. Your PCP is responsible for providing or coordinating necessary care for you 24 hours per day, 7 days a week. For additional medical information call BlueChoice On-Call, available 24 hours per day, 7 days a week.

In-Network versus Out-of-Network

As a BlueChoice Option member, you have the ability to receive services either from providers in the BlueChoice Option network or outside this network. Generally, you will pay less out of your own pocket if you elect in-network services.

- ***In-Network Services*** are those services that are either provided or coordinated by your PCP. Some services do not require PCP coordination. Please keep in mind that even though a referral is not required for certain services, you must select a provider from the network directory to receive in-network benefits. Services that do not require a PCP referral include:
  - *OB/GYN* services for the treatment of an obstetrical or gynecological-related condition.
  - *Covered Vision Care Services* – from a network ophthalmologist or optometrist (Routine vision services may not be covered under your policy – if you do not know if you have routine vision coverage, please call customer service at **(800) 368-0766**).
  - *Dermatological care* for skin-related conditions.
  - *Mental Health or Substance Abuse benefits* – You may contact Blue Cross/Blue Shield of Georgia Behavioral Health directly at **(800) 368-0766**, without contacting your PCP.

Pre-Existing Condition Limitation and Credit for Prior Coverage

There is no pre-existing condition limitation.

Emergencies

If you have a medical emergency, call 911 or proceed immediately to the nearest hospital emergency room. A "medical emergency" is defined as, "a condition or recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in their health being in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ."

Prescription Drugs

BlueChoice Option offers prescription drug coverage through a pharmacy network that includes many national pharmacy chains and select local pharmacies. Coverage is provided according to our preferred drug formulary for prescriptions written by a network physician and filled at a network pharmacy. Out-of-network prescriptions are also subject to the preferred drug formulary.

Summary of Limitations and Exclusions

Your *Summary Plan Description* will provide you with complete benefit coverage information. Some key limitations and exclusions, however, are listed below:

- Care or treatment that is not medically necessary
- Cosmetic surgery, except to restore function altered by disease or trauma
- Dental care and oral surgery; except for accidental injury to natural teeth, treatment of TMJ and extraction of impacted teeth
- Routine physical examinations necessitated by employment, foreign travel or participation in school athletic programs.
- Occupational related illness or injury
- Treatment, drugs or supplies considered experimental or investigational
- Surgical or medical care for: artificial insemination, in-vitro fertilization, reversal of voluntary sterilization, radial keratotomy, learning disabilities, mental retardation, hyperkinetic syndrome or autistic disease of childhood
- Smoking cessation products

BLUECHOICE POS PLAN
BENEFITS SUMMARY 09/01/2009 - 08/31/2010
(cont'd)

Prior Authorization

Your PCP must coordinate most in-network services. For in-network services, your PCP (or the specialist to whom you were referred by your PCP) will be responsible for ensuring that any surgical procedures or inpatient admissions obtain the necessary prior authorization. For out-of-network services, you should be sure that Blue Cross/Blue Shield Healthcare Plan of Georgia has authorized the following procedures prior to these services being rendered:

- Home health care services
- All outpatient surgery, including laproscopic and arthroscopic procedures
- Durable Medical Equipment over $250
- MRIs
- EMGs
- All scopes, including endoscopy and colonoscopy
- Myelography
- Cardiac catheterization

Note: This list is subject to change.

If you receive out-of-network treatment and prior authorization was not obtained, all charges will be denied. You, the member, will be responsible for all charges.

Vision

The coverage will be limited to one (1) eye examination for corrective lenses per member in a 12 month period, (corrective lenses is intended to include contacts as well as glasses). Office visit co-payment should be the same as for any other specialist $25.00 in-network and 70% of UCR, after the deductible, out-of-network.

The City will not cover lenses, frames, disposable or hard contact lenses and POS Members will be encouraged to utilize the BCBS discounted vision program.

Additional Information

Should you need additional information, the resources are your *Provider Directory/Member Guide*. You may also visit our web site at **www.bcbsga.com** for more information. If you have specific questions that require an answer from our representatives, please call one of the following numbers:

- Customer Service ..... **(800) 368-0766**
- Blue Cross/Blue Shield of Georgia Behavioral Health (Mental Health/Substance Abuse Services) ..... **(800) 368-0766**
- BlueChoice On-Call ..... **(888) 724-2583**

See Summary Plan Description for Complete Details

It is important to keep in mind that this material is a brief outline of benefits and covered services and is not a contract. Please refer to your *Summary Plan Description* for a complete explanation of covered services, limitations and exclusions.

Condition Management Programs

It really doesn't matter if you or someone on your health benefits plan just found out, or if you've known for a while, we know managing a chronic health condition can sometimes be tricky.

And, if you're trying to manage a health condition such as Asthma, Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD) or Heart Failure you'll probably agree that having access to new medical information and advice, tips and online tools specifically designed to help you manage your condition is invaluable. Neonatal Intensive Care Unit (NICU), Future Moms and 24/7 Nurse Line are also included. And, that's how using our Condition Management programs can come in handy!

What Is It and What's Included?

Our Condition Management programs are a service where you can talk with one of our registered nurses 24/7, or you can access information online to find ways to better manage your condition.

When you participate in this program, you have access to:

- Health evaluations and consultations as needed, to help you manage your condition
- Educational materials on prevention, self-monitoring charts, condition-specific care diaries and self-care tips

You'll also gain peace-of-mind because you'll know you have the tools and information you need to begin, or continue, taking control of your health condition. That alone is worth the price of admission; however, this is a free program!

What Else?

When you receive something you need, you're happy. And, we believe you'll be happy with the information and tools available in our Condition Management programs. So, don't delay the happy feelings! Give us a call at **(800) 638-4754** to enroll.

KAISER PERMANENTE HMO
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Connect To Your Health

With Kaiser Permanente, you'll have access to a wide variety of resources to help you get healthy and stay healthy – mind, body and spirit. Join a health class at your local medical center, where you can learn how to lower your cholesterol, manage your asthma, do yoga and more. Browse your newsletters to keep you up-to-date on the latest health news and advice. Create an online action plan to help you beat stress, lose weight, eat better or stop smoking. Connect to your medical record online and view your ongoing health conditions, lab results, past office visits and other online features. With everything we have to offer, a healthier life is within your reach.

Where do I receive medical Care?

When you join Kaiser Permanente, you pick your own personal physician from the group of doctors practicing at our medical centers, or from a network of affiliated private-practice doctors who practice in their own offices all over town. Currently, Kaiser Permanente has 16 conveniently located medical centers throughout metro-Atlanta: Alpharetta, Brookwood at Peachtree, Cascade, Crescent, Cumberland, Forsyth, Glenlake, Gwinnett, Henry, Panola, Southwood, TownPark, West Cobb, Stonecrest and North Gwinnett medical centers.

There are also private practice Affiliated Community Physicians available within the Kaiser Permanente service area. These physicians practice in their own offices. For a listing of the providers covered under the Kaiser Permanente plan, please refer to the HMO Physician directory or visit us online at ww.kp.org.

How do I choose or change my primary care physician?

We ask you to choose a personal physician upon enrollment so that you and your doctor can develop a partnership and work together to make sure you get the quality care you deserve. Your personal physician will guide and coordinate any care you receive in the hospital or from specialists. And having one doctor who arranges your care and knows your medical history helps you get the right care from the right people. The relationship you build with your personal physician can help you achieve and maintain both good health and good spirits.

You may choose a physician in family medicine, general practice, adult medicine or pediatrics/adolescent medicine as a personal physician. (Refer to the *Kaiser Permanente HMO Physician Directory* in your enrollment packet for specifics or kp.org.)

Simply call our Customer Service Department at **(404) 261-2590** locally or **(888) 865-5813** long distance.

How do I make an appointment?

It's really easy. There is one number to call to make or cancel appointments, speak with an advice nurse, or access after-hours urgent care – regardless of which Kaiser Permanente Medical Center you use. Call the Health Line at **(404) 261-2590** locally or **(888) 865-5813** long distance.

If your personal physician is one of our Affiliated Community Physicians, call his or her office directly to make an appointment.

To schedule or cancel appointments, you may call Monday through Friday from 7 a.m. to 7 p.m. The Health Line is open to speak with an advice nurse 24 hours a day, seven days a week.

What if I need to see a specialist?

When you select a personal physician, keep in mind that your choice will determine which specialists are available to you. Your personal physician has an established relationship with a specific group of specialty care doctors with whom he or she works with on a regular basis. By referring only to a certain group of specialists, your physician is better able to coordinate and oversee your care. You must get a referral from your personal physician in order to see a specialist. If you change your personal physician, the specialists available to you may also change.

As a Kaiser Permanente member, you have direct access to OB/GYNS, Dermatologists, Ophthalmologists, Optometrists, Psychiatrists and Behavioral Specialists. No referral is required.

KAISER PERMANENTE HMO
USER GUIDE 09/01/2009 - 08/31/2010 *(cont'd)*

What if I need to be admitted to the hospital?

Kaiser Permanente is affiliated with some of Atlanta's most prestigious hospitals. The personal physician you choose will determine the hospital to which you will be admitted. The hospitals used for most inpatient care are: Children's Healthcare of Atlanta at Scottish Rite, Emory Eastside Medical Center, Northside Hospital, Piedmont Hospital, Rockdale Hospital, Southern Regional Medical Center, WellStar Cobb Hospital, WellStar Douglas Hospital, WellStar Kennestone Hospital, and WellStar Paulding Hospital.

Get Connected

With Kaiser Permanente, you have secure, 24-hour access to portions of your health record online at kp.org. You also have increased access to your doctor and more tools to help you take a more active role in your health.

With these new time-saving features, you can:

- E-mail your doctor's office
- View certain lab test results
- Review past office visit information and future appointments
- Monitor your ongoing health conditions
- Access the health records of your children
- View your allergies

What should I do if I need emergency care?

If you have an emergency, call 911 or go to the nearest emergency room.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

If you are hospitalized, you should call (or have someone else call) the Kaiser Permanente Health Line – **(404) 261-2590** locally or **(888) 865-5813** long distance – to notify us of your hospital admission as soon as you can within 24 hours of your admission. This will allow us to consult with the physician providing your care and to coordinate further medical care.

You will pay a $100 copayment for emergency room services. (Emergency fees are waived if you're admitted.) Students attending school outside of the Kaiser Permanente service area will be covered for up to $500 for follow-up care associated with emergency services.

Do I fill out claim forms?

There are no claim forms required if care is provided, prescribed, or directed by a Kaiser Permanente physician. If there is a copayment, coinsurance, or deductible, you will be expected to pay at the time you receive the services.

If you have any questions about claims, please call a Claims Services Representative at **(404) 261-2590**.

What if I have additional questions?

Call Customer Services at **(404) 261-2590** locally or **(888) 865-5813** long distance. You can also visit our website at www.kp.org.

KAISER PERMANENTE
HMO BENEFITS 09/01/2009 - 08/31/2010

CATEGORY	09/01/2009 - 08/31/2010 – HMO PLAN DESIGN
Deductible	Not applicable
Office Visits	$10 co-pay
Specialist	$30 co-pay
Out-patient Surgery	$100 co-pay, facility visits (inclusive of High-tech Radiology and Colonoscopy)
Maternity Out-patient	$30 co-pay 1st visit, then 100% thereafter
Pediatric Office Visit	$10 co-pay
Immunizations	$10 co-pay, (well child care covered @100% up to age 2)
Prescription Brand	$30 co-pay at Kaiser per 30 day supply; $36 co-pay at Rite Aid or Walgreens per 30 day supply
Prescription Generic	$10 co-pay at Kaiser per 30 day supply; $16 co-pay at Rite Aid or Walgreens per 30 day supply
Mail Order	90 days supply @ 2 times Kaiser RX co-pay
In-patient Hospital Care	$200 co-pay per admission
Maternity In-patient	100% covered after $200 co-pay
Mental Health: Out-patient	$30 co-pay; unlimited visits
Ambulance	$100 co-pay
Emergency Room: In Plan	$100 co-pay
Emergency Room Out Plan	$100 co-pay
Urgent Care	$20 co-pay
Mental Health In-patient	$200 co-pay; unlimited days
Substance Abuse: Out-patient	$30 co-pay; unlimited visits
Substance Abuse: In-patient	Not covered
X-Rays & Lab work	100% covered if performed in a physicians office; $100 copay if performed in an out-patient hospital setting
Vision Eye Exam	$30 co-pay
Frames/Contact Lenses	Discounts Available
Infertility	$30 co-pay for diagnosis; 50% for treatment
Physical/Occupational Therapy (combined benefit)	$30 co-pay; limited to 20 visits
Speech Therapy	$30 co-pay; limited to 20 visits
DME Equipment	50% covered

KAISER PERMANENTE HMO
USER GUIDE 09/01/2009 - 08/31/2010 *(cont'd)*

For the plan year beginning on September 01, 2009 and ending on August 31, 2010.

CITY OF ATLANTA - ACTIVES	
PCP Selection	**If a PCP is not chosen upon enrollment, one will be assigned based upon the medical center closest to your home.**
Customer Services	**(404) 261-2590 (888) 865-5813 toll free Monday - Friday 8:30 a.m. until 9:00 p.m. Saturday, Sunday 8:00 a.m. until 2:00 p.m.**
Referral	**Self referral to Mental Health/Chemical Dependency, Dermatology and OB/GYN Care. All other speciality care services require prior authorization from your PCP.**

1 Some specific benefits have limitations.
2 Office visit copay may apply. Well-Child Visit: No Charge up to age 2.

Additional Information

- This benefit chart is a summary of the most frequently asked questions about benefits and their copayments. This is not a contract. Specific benefits, exclusions, and limitations are contained in the Group Agreement we have with your employer and the Evidence of Coverage you will receive. In the case of a conflict between this benefit chart and the Evidence of Coverage, the Evidence of Coverage will prevail. For specific questions about coverage, please ask your employer's benefits office or contact Kaiser Permanente Customer Services at **(404) 261-2590**. Benefits are subject to approval by the Georgia Department of Insurance.
- The following is a partial list of exclusions and limitations under this plan: Services that are not medically necessary; Certain exams and other services required for obtaining or maintaining employment or participation in employee programs, or required for insurance or licensing, or on court order or for parole or probation; Cosmetic services; Custodial or intermediate care; Services that an employer is required by law to provide; Experimental or investigational services; Eye surgery, including laser surgery, to correct refractive defects; Services that a government agency is required by law to provide; Services for conditions arising from military service; Services related to the treatment of morbid obesity (except certain health education programs are covered); Routine foot care; Sexual reassignment services; Non-human or artificial organs or their implantation; Reversal of voluntary infertility; Transportation and lodging expenses; Conditions covered by workers' compensation or under employer liability law; Services not generally and customarily available in our service area.
- In order for Services to be covered, a Plan Physician must determine that the Services are medically necessary to prevent, diagnose, or treat your medical condition. With the exception of emergency services, all covered Services must be provided, prescribed, authorized, or directed by a Plan Physician. You must receive the Services at a Plan Facility inside our Service Area, except where specifically noted to the contrary in the Evidence of Coverage. Certain covered services require pre-authorization by Medical Group.
- We use a formulary, which is a listing of medications that our physicians and pharmacists consider to be the most safe, useful and cost-effective ones available. A team of Kaiser Permanente physicians and pharmacists independently and objectively evaluates the scientific literature to identify the FDA-approved drugs best suited to treat specific medical conditions. Coverage for prescription drugs is limited to those drugs that are included on the Kaiser Permanente formulary. For a copy of the formulary brochure or for more information about the exception process, contact Customer Services at **(404) 261-2590**.
- For details on the benefit and claims review and adjudication procedures, please refer to your Evidence of Coverage.
- Kaiser Permanente maintains policies regarding the confidentiality, protection, and disclosure of personal health and member identifiable information, including policies related to access to medical records. If you have questions about our policies and procedures to maintain the confidentiality of personal information or would like a more comprehensive notice describing how Kaiser Permanente collects and uses personal information, please call Customer Services at **(404) 261-2590**.
- If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you or those of your eligible dependents who later have that coverage terminated for a reason other than fraud, misrepresentation or non-payment, may at that time be able to enroll in this health plan, provided that you request enrollment within 30 days after the other coverage ends. We may require sufficient proof of that other coverage and the reason for its termination. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

This plan summary is intended to only highlight some of the principal provisions of the plan. Please refer to the Group Agreement or Evidence of Coverage for further details of the plan or for specific limitations and exclusions.

CIGNA DENTAL PPO PLAN MEMBER GUIDE 09/01/2009 - 08/31/2010

Description of Benefits

The City of Atlanta offers the choice of two CIGNA Dental PPO plans (High Option or Low Option) for you and your eligible dependents. These comprehensive plans are administered by CIGNA Dental.* Most dental services, including preventive care, are covered. The annual dollar maximum for both the High and Low Options is $2,000.

Who Can Provide Services

The CIGNA Dental PPO plan is a preferred provider program. Members can seek care in- or out-of network. Participating CIGNA Dental network dentists have agreed to charge reduced fees for covered services; out-of-network dentists provide services at their usual fees. When you use an out-of-network dentist, you may be billed for the difference between the payment the dentist receives from CIGNA and his/her usual fees.

Proof of Coverage

After enrollment, you will receive a CIGNA Dental PPO ID card. However, the ID card is not required to access care.

Claims

Most network dentists will file claims on your behalf; out-of-network dentists may ask you to file the claim. CIGNA Dental will determine benefits, and payment will be made to the dentist or to you based on what is indicated on the claim form. Generally, you or your dentist should receive reimbursement in about three weeks.

How to Obtain Assistance

Help is only a phone call away! If you have questions about the dental plans, want to know the status of a claim, or need to know if specific services are covered, you can contact CIGNA Dental Member Service toll-free at **1-800-CIGNA24 (1-800-244-6224)**. You can also access personalized dental plan information when you register at ***www.myCIGNA.com***. Through myCIGNA.com, you can:

- Review your dental benefit plan information, including individual and family maximums and deductibles
- Find network dentists through the on-line provider directory
- Check on the status of a claim
- Access dental health news and information from trusted sources
- Print Dental ID cards

How to Appeal Claims

If you disagree with the processing of your claim, you have the right to ask for a review of the claim. Please refer to the "Right to Appeal" section of your benefit booklet for details.

Orthodontics in Progress

"Orthodontics in progress" refers to orthodontic care in progress at the time your dental coverage becomes effective. If your dependent is in the midst of orthodontic treatment when you join the plan, you may be eligible for some contribution.

Your CIGNA Dental PPO plan provides an orthodontic benefit; it covers orthodontics in progress, subject to your plan limitations. The orthodontics in progress benefit is calculated based on the coinsurance level for orthodontic treatment and the number of months of treatment remaining after your effective date. Benefit amounts are payable up to the lifetime dollar maximums or until the treatment is completed, which ever comes first.

Your CIGNA Dental PPO plan also covers orthodontics for new members who are in treatment prior to enrollment. Treatment will become effective the date the employee becomes effective. The original treatment must be submitted by the provider, which should include the total months of treatment, total fee (including retention) and the banding date. The contracted rate will be paid for the remaining months of treatment until the lifetime maximum has been met or until the treatment is completed, whichever comes first.

The patient balance due on the EOB will be incorrect because CIGNA will only be responsible to pay up to the PPO contracted amount for the remaining months of treatment. However, the patient will be liable for the provider's original case fee because that was the original financial agreement between the patient and provider.

** CIGNA Dental refers to the following operating subsidiaries of CIGNA Corporation: Connecticut General Life Insurance Company and CIGNA Dental Health, Inc., and its operating subsidiaries. The CIGNA Dental PPO is underwritten or administered by Connecticut General Life Insurance Company with network management services provided by CIGNA Dental Health, Inc., and certain of its operating subsidiaries.*

CIGNA DENTAL PPO PLAN MEMBER GUIDE 09/01/2009 - 08/31/2010 *(cont'd)*

CIGNA Dental PPO Benefit Summary Effective 09/01/2009 - 08/31/2010

This is a summary of benefits for your PPO plan. All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between in- and out-of-network.

BENEFITS	CIGNA DENTAL HIGH PPO		CIGNA DENTAL LOW PPO	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Maximum (Class I, II, and III Expenses)	$2,000	$2,000	$2,000	$2,000
Calendar Year Deductible Per Individual Per Family	 $50 $150	 $50 $150	 $50 $150	 $50 $150
Class I Expenses – Preventive & Diagnostic Care Oral Exams Cleanings (1 per 6-month consecutive period) Bitewing X-rays Fluoride Application Sealants Space Maintainers *(limited to non-orthodontic treatment)* Full Mouth X-rays Panoramic X-rays	100% No deductible	100% No deductible Subject to reasonable and customary allowances.	100% No deductible	100% No deductible Subject to reasonable and customary allowances.
Class II Expenses - Basic Restorative Care Emergency Care to Relieve Pain Fillings Oral Surgery - Simple Extractions Oral Surgery - All Except Simple Extraction Surgical Extraction of Impacted Teeth Major Periodontics ** Minor Periodontics ** Root Canal/Therapy	80%, After Deductible	80%, After Deductible Subject to reasonable and customary allowances.	80%, After Deductible	80%, After Deductible Subject to reasonable and customary allowances.
Class III Expenses - Major Restorative Care Anesthetics Relines, Rebases, and Adjustments Repairs - Bridges, Crowns and Inlays Repairs - Dentures Crowns Dentures Bridges Histopathologic Exams TMJ coverage (with separate $1000 lifetime max)	50%, After Deductible	50%, After Deductible Subject to reasonable and customary allowances.	50%, After Deductible	50%, After Deductible Subject to reasonable and customary allowances.
Class IV Expenses - Orthodontia Coverage for Eligible Children and Adults Lifetime Maximum	50% No Separate Deductible $1,500	50% No Separate Deductible $1,500	Not Covered	Not Covered
Missing Tooth Provision	Teeth missing prior to coverage under the CIGNA Dental plan are not covered.		Teeth missing prior to coverage under the CIGNA Dental plan are not covered.	
Pretreatment Review	Available on a voluntary basis when extensive work in excess of $500 is proposed.		Available on a voluntary basis when extensive work in excess of $500 is proposed.	
Out-of-Network Reimbursement	80th Percentile of Reasonable and Customary Allowances		80th Percentile of Reasonable and Customary Allowances	
Student Age	26		26	

** CIGNA Dental refers to the following operating subsidiaries of CIGNA Corporation: Connecticut General Life Insurance Company and CIGNA Dental Health, Inc., and its operating subsidiaries. The CIGNA Dental PPO is underwritten or administered by Connecticut General Life Insurance Company with network management services provided by CIGNA Dental Health, Inc., and certain of its operating subsidiaries.*

***** Perio coverage has a separate $1,000 lifetime maximum.***

CIGNA DENTAL PPO PLAN MEMBER GUIDE 09/01/2009 - 08/31/2010 *(cont'd)*

CIGNA Dental PPO/Indemnity Exclusions and Limitations

Procedure	Exclusions & Limitations
Late Entrants Limit	No coverage except for Class I (as defined in these plans) for 12 months.
Exams	1 per 6-month consecutive period.
Prophylaxis (Cleanings)	1 routine prophy or perio maintenance procedure per 6-month consecutive period (routine prophy is Class I; perio prophy is Class II).
Fluoride Treatments	1 per consecutive 12 months for participants younger than age 14.
Histopathologic Exams	Payable if the biopsy is covered. No coverage for other diagnostic tests.
X-rays (routine)	Bitewings: 1 set in any consecutive 12 month period. Limited to a maximum of 4 films per set.
X-rays (non-routine)	Full mouth or Panorex: 1 per 60 consecutive months.
Periapical x-rays	4 in 12 consecutive months if not performed in conjunction with an operative procedure
Intraoral occlusal x-rays	2 in 12 consecutive months
Models	Not covered.
Fillings	1 per tooth per 12 consecutive months (applies to replacement of identical surface fillings only).
Sealants	1 treatment per tooth per lifetime for children younger than age 14 only. Payable on unrestored permanent bicuspid or molar teeth only.
Minor Perio (non-surgical)	Root planing – 1 per quadrant per 36 consecutive months.
Perio Surgery	1 per 36 consecutive months per area of the mouth (same service).
Crowns and Inlays	Replacement limited to 1 per 84 consecutive months. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges. Replacement must be indicated by major decay.
Bridges	Replacement limited to 1 per 84 consecutive months, if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges.
Dentures and Partials	Replacement limited to 1 per 84 consecutive months, if unserviceable and cannot be repaired.
Relines, Rebases	Covered if more than 12 months after installation; 1 per 36 consecutive months.
Adjustments	Covered if more than 12 months after installation; 1 per 12 consecutive months.
Repairs - Bridges	Covered if more than 12 months after installation.
Repairs - Dentures	Covered if more than 12 months after installation.
Endodontics	Root canal re-treatment 1 per 24 consecutive months, if necessity demonstrated.

Benefit Exclusions:

- Services performed primarily for cosmetic reasons; Replacement of a lost or stolen appliance;
- Initial placement of a full or partial denture unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan; removal of only a permanent third molar will not qualify for an initial or replacement denture or bridge;
- Overdentures, personalization, precision or semi-precision attachments;
- Replacement of a bridge, denture or crown within 84 months following its initial date of insertion;
- Replacement of a bridge, denture or crown which can be made useable according to dental standards;
- Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion, the restoration of teeth which have been damaged by erosion, attrition or abrasion; bite registration; or bite analysis;
- Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars;
- Core buildup, labial veneers; Precious or semi-precious metals for crowns, bridges, pontics and abutments; crowns and bridges other than stainless steel or resin for participants under 16 years old;
- Implants are excluded with the exception of the prosthesis over the implant (Prosthesis being the crown, bridge or denture placed over the implant post.)
- Bite registrations; precision or semi-precision attachments; splinting; Surgical implant of any type including any prosthetic device attached to it;
- Instruction for plaque control, oral hygiene and diet;
- Dental services that do not meet common dental standards; Services that are deemed to be medical services;
- Services and supplies received from a hospital;
- Procedures for which a charge would not have been made in the absence of coverage, for which the person is not legally required to pay;
- Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service;
- Experimental or investigational procedures and treatments; Procedures which are not necessary and which do not have uniform professional endorsement;
- Any injury resulting from, or in the course of, any employment for wage or profit; Any sickness covered under any workers's compensation or similar law;
- Reasonable and Customary other that the defined percentile;
- IV sedation or general anesthesia, except when medically or dentally necessary and when in conjunction with covered complex oral surgery;
- Fees charged for broken appointments, claim form submission or sterilization;
- Services not included in the list of covered dental expenses, unless Connecticut General agrees to accept such expense as a covered dental expense, in which case payment will be made consistent with similar services which would provide the least expensive professionally satisfactory result;
- Crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth unless the tooth cannot be restored with an amalgam or composite resin filling due to major decay or fracture; Replacement of teeth beyond the normal complement of 32;
- Prescription drugs; Athletic mouth guards; Myofunctional therapy;
- Charges for travel time; transportation costs; or professional advice given on the phone;
- Procedures performed by a Dentist who is a member of the covered person's family (covered person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents);
- Any procedure, service, or supply which may not reasonably be expected to successfully correct the covered person's dental condition for a period of at least three years, as determined by CG; Temporary, transitional or interim dental services; Diagnostic casts, diagnostic models, or study models;
- Any charge for any treatment performed outside of the United States other than for Emergency Treatment (any benefits for Emergency Treatment which is performed outside of the United States will be limited to a maximum of ($100.00 - $200.00) per 12 consecutive month period);
- Procedures that are a covered expense under any other medical plan which provides group hospital, surgical, or medical benefits whether or not on an insured basis;
- Any charges, including ancillary charges, made by hospital, ambulatory surgical center or similar facility;
- To the extent that payment is unlawful where the person resides when the expenses are incurred;
- For charges which would not have been made if the person had no insurance; For charges for unnecessary care, treatment or surgery;
- To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- Services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- No payment will be made for expenses incurred by you or any one of your Dependents to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law; or an uninsured motorist insurance law.

Compar

PLAN	PLAN DESCRIPTION	SERVICE AREA	
BlueChoice Option Point-of-Service (POS)	The point-of-service (POS) plan offers in-network and out-of-network levels of coverage. In-network medical care is provided at a higher level of coverage when medical services are provided by the primary care physician (PCP) from the list of in-network providers. The out-of-network option allows you to see any provider for covered services, but your out-of-pocket costs will be higher than if you received care in-network. Members must choose a primary care physician (PCP) for each family member. The PCP can be a general/family or internal medicine physician, or pediatrician. The PCP will coordinate care for all members when the members receive medical care from in-network providers. Referrals are required from the PCP for treatment by in-network specialists. Members are **not** required to use in-network providers, but can decide to receive treatment from out-of-network providers at any time with no referrals. For out-of-network care, simply call the doctor and make an appointment. Remember: Your out-of-pocket expenses will be higher when you receive care from out-of-network providers. **NOTE: Members can receive in-network care from an OB-Gyn (one annual check-up), Dermatologist, and Ophthalmologist without a referral from the PCP.**	**In-Network** Covers the state of Georgia. **Out-of-Network** Covers the United States and foreign countries. See the BlueChoice POS Provider Directory or website for detailed information.	**In-Network** Individual = $ **Coinsurance** Some minimu Plan pays 100 **Copayments** $15 copay pe $25 copay pe $100 copay f component o **Out-of-Netw** Individual = $ **Coinsurance** Plan pays 70 **Out-of-Pock** Individual = $ Family = $6,0
Kaiser Permanente – HMO	A Health Maintenance Organization providing medical services as described. All care must be provided or arranged by your personal Kaiser Permanente physician – a physician located at one of the Kaiser Permanente medical centers or an affiliated private physician's office. If you have an emergency, call 911 or go to the nearest emergency room. No plan limit or maximum benefit. (Some specific benefits may have limitations.) Please list the chosen PCP's ID number on your application.	Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, Dalton, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Haralson, Heard, Henry, Lamar, Meriwether, Newton, Paulding, Pickens, Pike, Rockdale, Spalding and Walton Counties.	$10 copayme Well-child ca thereafter. $1 prostate chec covered in fu Hours center health servic visits: $30 co available; cor months for m 50% of charg

(<u>Please Note:</u> This comparison is only intended as a general description of the plans available through the City of Atlant

rison of Health Care Plans – Active Employees 09/

DEDUCTIBLES/COPAYMENTS	HOSPITAL SERVICES	EMERGENCY ROOM SERVICE	PRES
Deductible: $0 Family = $0 **In-Network** um copayment are required. 0% for most services **In-Network** r office visit, physical examination or well child visit from PCP. r OB-Gyn examination and specialty physician visit or outpatient surgery outside a physician's office (facility nly) **ork Deductible** $ 300 Family = $ 900 **Out-of-Network** % after the deductibles are satisfied by the members. **et Maximum** $2,000 per calendar year 000 per calendar year	**In-Network** Plan pays 100% after a $200 copay per inpatient admission. **Out-of-Network** Plan pays 70% after deductible	**In-Network** = $75 copayment, waived if admitted **Out-of-Network** = $75 copayment, waived if admitted Non-emergency use of the emergency room is not covered. This applies to medical care received in-network and out-of-network.	**In-Network** - Retail - Generic - $10 Brand Formu Brand Non-F - Mail order - Generic- $20 Brand Formu Brand Non-F **Out-of-Netw** after deductib
nt per primary; $30 copayment for specialty care office visits. re covered in full up to age 24 months: then $10 per visit 0 copayment for routine check-ups; $30 copayment for Pap smear, ks, and follow-up visits. Maternity care and one postnatal visit ll. $20 copayment for after-hours care at a Kaiser Permanente After or an Affiliated Community After Hours Center. Inpatient mental es are covered after a $200 copayment. Outpatient mental health payment per visit. Detoxification for alcohol and drug abuse ntact customer services for details. $50 copayment every six aintenance allergy serum. $10 copayment for allergy injections. ges for infertility treatment and prescriptions.	Semi-private or private room if medically necessary after $200 copayment. ICU, CCU and miscellaneous hospital charges covered in full at participating hospitals after applicable copayment. Hospital stay must be authorized by a physician. See physician directory for hospital listing. Inpatient surgery covered at 100% after $200 copayment when authorized. $100 copayment for outpatient surgery.	Emergency care for illness or injury is covered 24 hours a day. (If you have an emergency call 911 or go to the nearest emergency room.) $100 copayment per emergency room visit. Emergency care copayment waived if admitted. $100 copayment per trip for ambulance services.	Up to a 30 da and certain ac $10 copay ge Kaiser Perma $16 copay ge Rite Aid or W Time released Norplant and copay generic Kaiser Perma copay generic Rite Aid or W the number o effective not t

a.)

/01/2009 - 08/31/2010

CRIPTION DRUGS	CARE OUTSIDE SERVICE AREA	PRE-EXISTING CONDITIONS	VISION CARE	MAJOR EXCLUSIONS
) lary - $25| ormulary - $40 . lary - $50 ormulary - $80 **ork** = plan pays 70% ble	Only out-of-network benefits are available, subject to calendar year deductible, payable at 70% UCR.	Full coverage is provided for pre-existing conditions	**In-Network** Coverage is available for eye illness or injury only when coordinated through your primary (PCP) or network ophthalmologist. **Out-of-Network** Coverage is available for eye illness or injury by any out-of-network ophthalmologist. **Discount Vision Care** A discount is available when care is received from participating Lenscrafters for eye exams, frames, lenses or contact lenses. You must show your medical ID card.	A list of exclusions is available by consulting your benefits staff, BCBS Ga Members Services or the Summary Plan Description when it is available. This includes medical care which is non-covered, not medically necessary, or experimental or investigational in nature.
y supply of medication ccessories and supplies: neric/$30 copay brand at nente Pharmacies. neric/$36 copay brand at Valgreens. d drugs, including Depo-Provera: $10 c/$30 copay brand at nente Pharmacies. $16 c/$36 copay brand at Valgreens multiplied by f months the drug is to exceed $200.	Emergency care is covered after $100 copayment. Emergency care copayment waived if admitted. Bills for services received outside service area must be submitted to Kaiser Permanente for payment within 90 days. Visiting member benefits available for 90 days in other Kaiser Permanente regions.	Full coverage is provided for pre-existing conditions	When obtained from participating eye care providers, eye examinations for corrective lenses are covered. $30 co-pay. You receive a 25% discount off of eyeglasses, a 15% discount off of regular contact lenses, and a 5% discount off of disposable contact lenses.	Services and supplies not provided, arranged, or authorized by a Kaiser Permanente physician, except for out-of-plan emergency care. Long-term physical rehabilitation services, extraction of wisdom teeth, hearing aids and most disposable supplies are not covered.

HUMANA (COMPBENEFITS) DENTAL ACCESS PLAN 09/01/2009 - 08/31/2010

Welcome to *Dental Access*

Humana (CompBenefits) is pleased to offer you and your family an innovative option in dental benefits called *Dental Access*. Preventive dental care is an important part of everyone's health care needs. *Dental Access* is designed to meet your needs by providing affordable coverage and reducing the cost associated with maintaining good dental health.

DENTAL ACCESS OFFERS:

Access

- Freedom to use any dentist with benefit incentives to use participating network providers
- Freedom for each family member to have their own dentist
- Immediate access to Specialists at fixed copayments
- No referral required for specialty care

Savings

- No deductibles
- Fixed member in-network copayments with no balance billing
- Scheduled reimbursement for out-of-network dental services
- No benefit waiting periods

Convenience

- No claims forms for in-network services
- No pre-authorization needed to change dentist or to use non-participating providers

Dental Access provides the protection, flexibility and the coverage you and your family desire. The plan offers both in-network and out-of-network benefits, that gives you and your family the ability to receive care from any dentist in the community. While most of the time there will be higher out-of-pocket costs for care obtained out-of-network, the plan provides you the comfort of having this flexibility.

IN-NETWORK COVERAGE

Private practice dentists who contract with Humana (CompBenefits) provide treatment and services for you and your family. These dentists agree to provide the comprehensive benefits outlined in your dental plan and to accept the Humana (CompBenefits) fee schedule. Upon enrolling in the plan, you may seek treatment from any dentist listed in the network directory. Your dentist will charge specific copayments for covered procedures. This means fewer out-of-pocket expenses for you when using your in-network coverage. See the Schedule of Benefits for exact copayments and reimbursements per dental procedure.

THE IN-NETWORK ADVANTAGE

- Preventive and diagnostic services covered at 100 percent, including routine cleanings, examinations, X-rays, fluoride treatments and emergency palliative treatment (Office visit copayment may apply)
- Coverage for restorative and specialty care with fixed copayments
- Flexibility to choose any network dentist at any time
- Family Choice, which allows each family member to select a different general care dentist
- Immediate specialty access
- Quality assessment of participating dental offices

Humana (CompBenefits) is very concerned with providing you and your family with access to quality care and therefore takes the appropriate measures to verify the professional credentials of dentists applying for participation in the Humana (CompBenefits) network. On-site quality assurance inspections are performed on participating dental offices on an annual basis.

OUT-OF-NETWORK COVERAGE

If you should decide to seek services outside of Humana (CompBenefits') network of participating dental providers, you would simply receive dental care from any licensed, practicing dentist. You would pay for the treatment rendered, complete a claim form, and submit the form to Humana (CompBenefits) for direct reimbursement to you of approved claims. There are no deductibles or waiting periods to receive coverage. Refer to Benefits, Limitations and Exclusions for a detailed review of benefits. **A fixed dollar amount is reimbursed on each procedure. The applicable Preventive & Diagnostic Office Visit Copayment is deducted from the maximum reimbursement amount for preventive and diagnostic procedures.**

Your responsibility under this option includes any cost that remains after the insurance reimbursement and maximum benefit limitations. Your plan also covers a portion of the cost associated with emergency dental care that you may receive from a non-participating provider.

HUMANA (COMPBENEFITS) DENTAL ACCESS PLAN 09/01/2009 - 08/31/2010 *(cont'd)*

BENEFIT SUMMARY

Below is a brief summary of the dental benefits under the *DENTAL ACCESS* plan. This is provided as an overview document. Details about your coverage are outlined in your Schedule of Dental Benefits. Should there be any difference between this summary and the Benefits Schedule, the terms and conditions of the Benefits Schedule will prevail.

DENTAL ACCESS

	In-Network	Out-of-Network
Benefit Level	See Benefit Schedule	Schedule Reimbursements
Preventative & Diagnostic Office Visit Co-pay	None	None
Annual Deductible	$0.00	$0.00
Annual Benefit Maximum	Unlimited	Unlimited

BENEFIT SUMMARY FOR COVERED DENTAL SERVICES

	You Pay Humana (CompBenefits) Provider	Humana (CompBenefits) Reimburses You
PREVENTIVE & DIAGNOSTIC SERVICES		
Periodic Oral Examination*	No charge	$24.00
Bitewing X-rays – Four*	No charge	$27.00
Panoramic Film*	No charge	$50.00
Prophylaxis – Adult*	No charge	$45.00
Prophylaxis – Child*	No charge	$30.00
Fluoride – Child (including prophylaxis)*	No charge	$35.00
Sealants (permanent molars only)*	No charge	$23.00
BASIC SERVICES		
Amalgam Filling – Two Surface	$0.00	$52.00
Composite Filling – Two Surface Anterior	$0.00	$52.00
Prefabricated Steel Crown – Primary	$90.00	$19.00
Pulp Cap – Direct (excluding final restoration)	$0.00	$23.00
Root Canal – Bicuspid	$0.00	$289.00
Scaling and Root Planning – Per Quad (4+ teeth per quad)*	$0.00	$79.00
MAJOR SERVICES		
Crown-Porcelain Fused To Noble Metal	$354.00	$136.00
Complete Full Upper Dentures*	$472.00	$132.00

ORTHODONTIC COVERAGE

Children Coverage	$3,035 maximum fee	$365.00
Adult Coverage	$3,325 maximum fee	$165.00

Services indicated with an asterisk (*) are subject to frequency and/or age limitations. Consult your Benefits Schedule for a complete list of these frequencies, limitations and exclusions that apply.

This material is a brief outline of benefits and covered services. The full Schedule of Benefits with a complete explanation of services, exclusions, and limitations will be included in your enrollment book.

HUMANA (COMPBENEFITS) DHMO DENTAL PROGRAM 09/01/2009 - 08/31/2010

Welcome to the Humana (CompBenefits) DHMO Dental Program – Preselect

Regular professional dental care is important to maintaining healthy teeth and gums. With rising dental fees, it can also be quite expensive.

Your selection of the **DHMO** Dental Program will provide professional dental care while helping you control dental expenses.

If you enroll in dental coverage, you must remain in the program selected for a period of 12 months.

With the **DHMO** program, you have coverage for preventive, basic and major services, and you can take advantage of:

- **Lowest payroll deduction option!**
- **No deductibles**
- **No annual maximum**
- **Generally lower out-of-pocket expenses than a traditional program.**

  (See your Schedule of benefit copayments for more details.)

CHOICE OF DENTISTS

Humana (CompBenefits) contracts with dentists in the community to provide quality care to our members. To receive benefits, you and each of your dependents must select a dental facility from the Humana (CompBenefits) list of participating dental offices. Dentists undergo a thorough review process prior to participation in the network. A licensed general dentist and staff of professional auxiliaries operate each office. If you wish, you may select a different dentist for each covered dependent so that each covered dependent can receive dental care where it is most convenient.

MAKING AN APPOINTMENT WITH YOUR DENTIST

You may schedule appointments by calling the dental office you selected after your effective date of coverage. When you call to schedule your appointment, notify the office that you are a member of the Humana (CompBenefits) dental plan. Call **(800) 342-5209** if you are not certain about your dental provider selection.

CHANGING YOUR SELECTION OF DENTIST

Members may wish to transfer to another participating dental office or provider. Transfer requests may be made in writing to Humana (CompBenefits) or may be requested by calling Humana (CompBenefits') Member Support Department at **(800) 342-5209**. Outstanding balance must be cleared before a transfer request will be honored. Requests received by Humana (CompBenefits) during the first 15 days of the month will become effective the first of the following subsequent month. Members may not be seen at 2 different participating dental offices during the same one-month period. Humana (CompBenefits) may open and close enrollment at any participating dental offices and providers from time to time.

SPECIALIST CARE

Certain dental procedures require the services of a specialist (i.e. some oral surgery, endodontics, periodontics and pedodontics). In those cases, you must seek treatment from Humana (CompBenefits) specialty providers to receive appropriate discounted fees. A referral is needed from your general dentist in order to receive services from a specialist in the DHMO network. Access to orthodontic discounts does not require a referral!

OPTUMHEALTH VISION BENEFITS SUMMARY 09/01/2009 - 08/31/2010

CITY OF ATLANTA – Program Year Effective 09/01/2009 - 08/31/2010 – Underwritten by United HealthCare Insurance Company

BENEFITS AT A OPTUMHEALTH VISION NETWORK PROVIDER	
COMPREHENSIVE VISION EXAM ($15 copay; Once Every 12 Months)	A vision examination is provided by a network optometrist or ophthalmologist, after applicable copay.
MATERIALS ($25 copay)	The materials copay is a single payment that applies to the entire purchase of eyeglasses (lenses and frames), or contacts in lieu of eyeglasses.
PAIR OF LENSES (for eyeglasses) (Once Every 12 Months)	**Standard scratch-resistant coating, tints and UV are covered-in-full.**
• Standard single vision • Standard lined bifocal • Standard lined trifocal • Standard lenticular	**Lens Options** – Options such as progressive lenses, polycarbonate lenses and anti-reflective coating may be available at a discount.
FRAMES (Once Every 12 Months)	Receive a $50 wholesale frame allowance (approximate retail value of $120 to $150) at private practice providers, or a minimum $130 frame allowance at retail chain providers.
CONTACT LENSES (in lieu of eyeglasses) (Once Every 12 Months)	
• Covered-in-full elective contact lenses	The fitting/evaluation fees, contacts (including disposables), and up to two follow-up visits are covered-in-full (after applicable copay) for many popular brands, such as Acuvue by Johnson & Johnson and Optima by Bausch & Lomb. If covered disposable contact lenses are chosen, up to 6 boxes (depending on prescription) are included when obtained from a network provider. It is important to note that OptumHealth Vision's covered-in-full contact lenses may vary by provider.
• All other elective contacts	A $150 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside of OptumHealth Vision's covered-in-full contacts (materials copay does not apply). Toric, gas permeable, and bifocal contacts are all examples of contacts that are outside of our covered-in-full selection.
• Necessary contact lenses*	Covered-in-full (after applicable copay).
REFRACTIVE EYE SURGERY	OptumHealth Vision participants receive access to discounted refractive eye surgery from numerous provider locations throughout the United States. To find a participating laser eye surgeon in your area, visit our Web site at www.myoptumhealth.com.

BENEFITS AT AN OUT-OF-NETWORK PROVIDER

SERVICE	AMOUNT	
Exam		
Optometrist	up to	$40
ophthalmologist	up to	$40
Lenses		
Single Vision	up to	$40
Bifocal	up to	$60
Trifocal	up to	$80
Lenticular	up to	$80
Frames	up to	$45
Contact Lenses (in lieu of eyeglasses)		
Elective	up to	$150
Necessary*	up to	$210

If you choose an out-of-network provider, you will need to send your itemized receipts, with the primary-insured's unique identification number and the patient's name and date of birth, to:

OptumHealth Vision
P. O. Box 30978
Salt Lake City, UT 84130

Please note: Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement.

** Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery; To correct extreme vision problems that cannot be corrected with spectacle lenses; With certain conditions of anisometropia; With certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact OptumHealth Vision concerning the reimbursement that OptumHealth Vision will make before you purchase such contacts.*

OPTUMHEALTH VISION BENEFITS SUMMARY 09/01/2009 - 08/31/2010 *(cont'd)*

Important to Remember:

- Always identify yourself as a OptumHealth Vision participant when making your appointment. This will assist your provider in obtaining a claim authorization number prior to your visit.
- Benefits available every 12 months, based on last date of service.
- Your $150 contact lens allowance is applied to the fitting/evaluation fees as well as the purchase of contact lenses. For example, if the fitting/evaluation fee is $30, you will have $120 towards the purchase of contact lenses. The allowance may be separated at some retail chain locations between the examining physician and the optical store. Toric, gas permeable, and bifocal contacts are all examples of contacts that are outside of our covered-in-full selection.

The following Services and Materials are excluded from coverage under the Policy:

1. Post cataract lenses
2. Non-prescription items
3. Medical or surgical treatment for eye disease, that requires the services of a physician
4. Worker's Compensation services or materials
5. Services or materials that the patient, without cost, obtains from any governmental organization or program
6. Services or materials that are not specifically covered by the Policy
7. Sunglasses, plain or prescription
8. Replacement or repair of lenses and/or frames that have been lost or broken
9. Cosmetic extras, except as stated in the Policy's Table of Benefits.

Provider Locator

With OptumHealth Vision you are able to choose from network private practice providers and retail chain providers. Prior to enrolling in or using the OptumHealth Vision program, if you would like to identify a network provider, visit OptumHealth Vision's Website – www.myoptumhealth.com and provide locator or call OptumHealth Vision's Provider Locator Service at **1-800-839-3242** and follow the voice prompts:

- Enter the primary insured's unique identification number.
- Enter the ZIP code for the area you wish to check.
- After each entry, the system will repeat what you have entered and ask that you "Press 1" if correct, or "Press 2" if incorrect.
- The system will then identify up to three network providers in the requested ZIP code area.
- If you wish to hear the selections again, "Press 1". To enter another five-digit ZIP code, "Press 2".

Prior to using your benefits at a network provider, please call the provider and make an appointment. Please inform the provider that you are a OptumHealth Vision participant.

PLEASE NOTE: If there are differences in this document and the Group Policy, the Group Policy is the governing document. Please retain this Benefit Summary and Vision Care Program description that includes detailed benefit information and instructions on how to use the program. Customer Service is available toll-free at **1-800-638-3120** *from 8:00 am to 11:00 pm, Monday thru Friday, and from 9:00 am to 6:30 pm on Saturdays.*

ID cards will be issued to all enrollees.

EMPLOYEE COST OF HEALTH COVERAGE 09/01/2009 - 08/31/2010

You and the City of Atlanta share the cost of your health insurance coverage. The cost of the coverage varies from year to year.

Your costs for health coverage from 09/01/2009 - 08/31/2010 are as follows:

	BLUE CROSS BLUE SHIELD POS		KAISER PERMANENTE HMO	
	Employee Cost	***City Cost***	***Employee Cost***	***City Cost***
Bi-Weekly Rates				
Employee Only	$61.32	$143.08	$51.86	$121.00
Employee & Child(ren)	$107.31	$250.39	$90.74	$211.74
Employee & Spouse/Domestic Partner	$153.30	$357.71	$129.64	$302.50
Employee & Family	$202.39	$472.25	$171.12	$399.29

EMPLOYEE COST OF OPTIONAL DENTAL & VISION COVERAGE 09/01/2009 - 08/31/2010

Employee Cost of Optional Dental Coverage

You and the City of Atlanta share the cost of your optional dental insurance coverage. The cost of the coverage varies from year to year.

Your costs for dental coverage from 09/01/2009 - 08/31/2010 are as follows:

OPTIONAL DENTAL PLANS

	CIGNA DENTAL PPO PLANS				OHS A HUMANA (COMPBENEFITS) CORPORATION			
	High Option (Orthodontics)		Low Option (No Orthodontics)		Access Plan (Orthodontics)		Pre-Select Plan (No Orthodontics)	
	Employee Cost	***City Cost***	***Employee Cost***	***City Cost***	***Employee Cost***	***City Cost***	***Employee Cost***	***City Cost***
Bi-Weekly Rates								
Employee Only	$3.64	$8.50	$3.64	$8.49	$2.09	$4.88	$1.41	$3.30
Employee & Child(ren)	$7.73	$18.03	$7.06	$16.48	$4.07	$9.49	$2.57	$5.99
Employee & Spouse/Domestic Partner	$7.43	$17.33	$7.43	$17.33	$4.27	$9.96	$2.81	$6.56
Employee & Family	$12.22	$28.52	$11.21	$26.16	$6.46	$15.07	$4.35	$10.15

Employee Cost of Optional Vision Coverage

You must pay the entire cost of your optional vision insurance coverage. The cost of the coverage varies from year to year.

Your costs for vision coverage from 09/01/2009 - 08/31/2010 are as follows:

OPTIONAL VISION PLAN

	OPTUMHEALTH VISION
	Employee Cost
Bi-Weekly Rates	
Employee Only	$2.22
Employee & Child(ren)	$4.87
Employee & Spouse/Domestic Partner	$4.64
Employee & Family	$6.27

EMPLOYEE LIFE INSURANCE
09/01/2009 - 08/31/2010

Open Enrollment Changes

If you wish to add a dependent or change your coverage from no coverage to one time basic salary, or increase your additional coverage by more than $20,000, **you must complete a Health Statement** at any Open Enrollment meeting or you may make an appointment **between July 6th and July 22nd** by calling the DHR Insurance Division at **(404) 330-6036**. These changes are subject to the approval by the Greater Georgia Life underwriters. However, you may drop your coverage, or any dependent coverage, by checking decline to the right of the coverage and delete at the bottom of the form (above your signature).

You make a great investment in your family. You spend time with them. You care for them. You work for them, and if you're not there for them, you want them protected. The City of Atlanta provides you with a basic amount of Group Life insurance and Accidental Death and Dismemberment Insurance (AD&D) to help protect your loved ones in the event of your death. There is an additional "In the Line of Duty" Benefit for First Responders in the amount of 50% Base Salary Covrage. The City of Atlanta also provides you with the opportunity to apply for Additional Life insurance from Greater Georgia Life.

Following is an outline of the Life Insurance benefits that are available. This information is provided as an overview and does not constitute a contract. Please refer to the Life Insurance policy for detailed explanation of policy provisions.

You DO NOT have to complete an application UNLESS you are making a change.

Eligibility

To be eligible for this plan:

- You must be an active full-time or part-time permanent employee of The City of Atlanta.
- To enroll in the Voluntary Additional Life plan, you must be enrolled in the Basic Life plan.
- For Dependent Life insurance your spouse or children must not be full-time members of the armed forces of any country.

Employee Coverage Amount

- The Basic Life plan provides a benefit equal to one times your annual salary to a maximum of $250,000.
- The Additional Life plan allows you to select increments of $10,000 up to $200,000.
- Accidental Death and Dismemberment insurance (AD&D) is also provided in the amount that is equal to the Basic Life Insurance coverage.
- **Additional Benefit for Line of Duty Accident**
  If Loss becomes payable under the Policy for You for Accidental Loss of Life or Loss due to Accidental Injury, and such Loss occurs as the direct result of Injury sustained in a Line of Duty Accident while employed as a Public Safety Officer, the amount payable from the Schedule of Losses will be increased by 50%.
- All late applications and requests for coverage increases require medical underwriting approval.

Spouse and Dependent Coverage Amount

Dependents Life Insurance is also available and would provide the following coverage:

Spouse: $5,000

Child between birth and six months: $600

Child between six months and 19 years (26 if a full-time student): $5,000

All late applications and requests for coverage increases will require medical underwriting approval by Greater Georgia Life.

A Surviving Spouse who is insured at the time an Employee or Retiree passes away will be eligible to continue his/her $5,000 Life Insurance coverage.

IMPORTANT NOTICE:

You, as an employee, are free to designate a minor as the beneficiary of your life insurance proceeds. However, no benefits will be paid to a child who has not yet reached the age of majority (18 years old, in Georgia). Instead, you may want to designate a guardian or trustee for the benefit of the minor. If you are considering appointing a minor as your beneficiary, you may want to consult with an attorney.

EMPLOYEE LIFE INSURANCE
09/01/2009 - 08/31/2010 *(cont'd)*

Cost of Coverage

If you select Basic Life Insurance (one times your annual salary), The City pays for the first $10,000 of coverage for Basic Life and AD&D insurance; you pay the remaining part. The City does not contribute toward the cost of Dependent Life Insurance and Additional Life Insurance. **PLEASE NOTE: You must choose the one time Basic Salary to receive the $10,000 coverage paid by The City.** Your costs for Life Insurance are as follows:

BASIC LIFE PLAN: 1 TIMES ANNUAL SALARY

Amount of Insurance	Cost of Insurance	Employee Monthly Premium
1 times your annual salary (1st $10,000 paid by The City)	$0.150 (per $1,000 of benefit)	Refer to the rate schedule

ACCIDENTAL DEATH & DISMEMBERMENT PLAN: 1 TIMES ANNUAL SALARY

Amount of Insurance	Cost of Insurance	Employee Monthly Premium
1 times your annual salary (1st $10,000 paid by The City)	$0.03 (per $1,000 of benefit)	Refer to the rate schedule

VOLUNTARY ADDITIONAL LIFE PLAN

Amount of Insurance: Increments of $10,000 up to $200,000 not to exceed three times your annual salary
Cost of Insurance: $0.440 per $1,000 of benefit – See below for employee monthly premium

AMOUNT OF INSURANCE ($)	EMPLOYEE MONTHLY PREMIUM ($)	AMOUNT OF INSURANCE ($)	EMPLOYEE MONTHLY PREMIUM ($)
10,000	4.40	110,000	48.40
20,000	8.80	120,000	52.80
30,000	13.20	130,000	57.20
40,000	17.60	140,000	61.60
50,000	22.00	150,000	66.00
60,000	26.40	160,000	70.40
70,000	30.80	170,000	74.80
80,000	35.20	180,000	79.20
90,000	39.60	190,000	83.60
100,000	44.00	200,000	88.00

DEPENDENTS PLAN

Amount of Insurance		Employee Monthly Premium	
Spouse:	$5,000	Spouse:	$4.00
Children Birth – 6 months:	$600	Child:	$1.19
Children 6 months – 19 years:	$5,000		
Full-time students to 26 years:	$5,000		
Surviving Spouse (if enrolled prior to the employee passing away):	$5,000	Surviving Spouse Monthly Premium	$10.00

EMPLOYEE LIFE INSURANCE
09/01/2009 - 08/31/2010 *(cont'd)*

Employee Coverage Effective Date

Please contact your employee benefits representative for more information regarding the following requirements that must be satisfied for your insurance to become effective. You must satisfy:

- Eligibility requirements
- An *eligibility waiting period*
- An *evidence of insurability* is required at this time for any coverage you have previously declined or for an upgrade in coverage and requests for an increase to the Voluntary Additional Plan in excess of $20,000
- An employee must be actively at work. This means that if you are not *actively at work* on the day before the scheduled effective date of insurance including Dependents Life Insurance, your insurance will not become effective until the day after you complete 31 days of *active work* as an eligible employee.

Suicide Exclusion

Under the Additional Life plan, there is an exclusion for death resulting from suicide or other intentionally self-inflicted injury. The amount payable will exclude amounts that have not been continuously in effect for at least two years on the date of death.

Portability

If you leave your employment, you may be eligible to continue your group life insurance from Greater Georgia Life through the Portability provision. Please see your employee benefits representative for additional information.

Conversion

If your insurance ends because your employment terminates, you may be eligible to convert the terminated coverage to an individual life insurance policy without providing evidence of insurability. Please see your employee benefits representative for additional information.

If You Become Terminally Ill

Under the Accelerated Benefit provisions, you may be eligible to receive up to 75% of your Basic Life insurance and Voluntary Additional Life insurance if you become terminally ill, have a life expectancy of less than 12 months and meet other eligibility requirements. This benefit allows you to use the proceeds as you desire – whether to cover medical expenses or to maintain your quality of life. The amount paid under the *Accelerated Benefit* provision would reduce the amount of Basic Life insurance and Voluntary Additional Life insurance payable upon your death.

Increases of Coverage

If you wish to enroll or increase your additional coverage in excess of $20,000, **you must make an appointment by calling DHR Insurance Division at (404) 330-6036 or you will have to complete the application and insurability form at one of the Open Enrollment Meetings or with a Greater Georgia Representative**. You will have to complete an application and a Proof of Insurability Form that will be evaluated and approved or denied by Greater Georgia Life. Your coverage will take effect after approval by the carrier's underwriters. NOTE: You may be required to have a physical at your expense.

If You Have Questions

If you have any questions about eligibility enrollment or life insurance coverage, contact the DHR Insurance Division at **(404) 330-6036**.

If you have questions regarding conversion of your life insurance coverage, call Greater Georgia Life at **(800) 962-1672**.

Greater Georgia Life Insurance Company

Greater Georgia Life Insurance Company (Greater Georgia Life) has earned a solid reputation for its quality products, expert resources, superior services, steady growth, innovation and strong financial performance. Founded in 1982, Greater Georgia Life is a leader in the group disability and life insurance market.

LIFE INSURANCE RATE SCHEDULE
09/01/2009 - 08/31/2010

Basic Life and Accidental Death and Dismemberment Costs

ANNUAL SALARY ROUNDED UP TO NEXT $1,000	LIFE BENEFIT	AD&D BENEFIT	YOU PAY	THE CITY PAYS
$13,000	$13,000	$13,000	$0.54	$1.80
$14,000	$14,000	$14,000	$0.72	$1.80
$15,000	$15,000	$15,000	$0.90	$1.80
$16,000	$16,000	$16,000	$1.08	$1.80
$17,000	$17,000	$17,000	$1.26	$1.80
$18,000	$18,000	$18,000	$1.44	$1.80
$19,000	$19,000	$19,000	$1.62	$1.80
$20,000	$20,000	$20,000	$1.80	$1.80
$21,000	$21,000	$21,000	$1.98	$1.80
$22,000	$22,000	$22,000	$2.16	$1.80
$23,000	$23,000	$23,000	$2.34	$1.80
$24,000	$24,000	$24,000	$2.52	$1.80
$25,000	$25,000	$25,000	$2.70	$1.80
$26,000	$26,000	$26,000	$2.88	$1.80
$27,000	$27,000	$27,000	$3.06	$1.80
$28,000	$28,000	$28,000	$3.24	$1.80
$29,000	$29,000	$29,000	$3.42	$1.80
$30,000	$30,000	$30,000	$3.60	$1.80
$31,000	$31,000	$31,000	$3.78	$1.80
$32,000	$32,000	$32,000	$3.96	$1.80
$33,000	$33,000	$33,000	$4.14	$1.80
$34,000	$34,000	$34,000	$4.32	$1.80
$35,000	$35,000	$35,000	$4.50	$1.80
$36,000	$36,000	$36,000	$4.68	$1.80
$37,000	$37,000	$37,000	$4.86	$1.80
$38,000	$38,000	$38,000	$5.04	$1.80
$39,000	$39,000	$39,000	$5.22	$1.80
$40,000	$40,000	$40,000	$5.40	$1.80
$41,000	$41,000	$41,000	$5.58	$1.80
$42,000	$42,000	$42,000	$5.76	$1.80
$43,000	$43,000	$43,000	$5.94	$1.80
$44,000	$44,000	$44,000	$6.12	$1.80
$45,000	$45,000	$45,000	$6.30	$1.80
$46,000	$46,000	$46,000	$6.48	$1.80
$47,000	$47,000	$47,000	$6.66	$1.80
$48,000	$48,000	$48,000	$6.84	$1.80
$49,000	$49,000	$49,000	$7.02	$1.80
$50,000	$50,000	$50,000	$7.20	$1.80
$51,000	$51,000	$51,000	$7.38	$1.80
$52,000	$52,000	$52,000	$7.56	$1.80
$53,000	$53,000	$53,000	$7.74	$1.80
$54,000	$54,000	$54,000	$7.92	$1.80
$55,000	$55,000	$55,000	$8.10	$1.80
$56,000	$56,000	$56,000	$8.28	$1.80
$57,000	$57,000	$57,000	$8.46	$1.80
$58,000	$58,000	$58,000	$8.64	$1.80
$59,000	$59,000	$59,000	$8.82	$1.80
$60,000	$60,000	$60,000	$9.00	$1.80
$61,000	$61,000	$61,000	$9.18	$1.80
$62,000	$62,000	$62,000	$9.36	$1.80
$63,000	$63,000	$63,000	$9.54	$1.80
$64,000	$64,000	$64,000	$9.72	$1.80
$65,000	$65,000	$65,000	$9.90	$1.80
$66,000	$66,000	$66,000	$10.08	$1.80
$67,000	$67,000	$67,000	$10.26	$1.80
$68,000	$68,000	$68,000	$10.44	$1.80
$69,000	$69,000	$69,000	$10.62	$1.80
$70,000	$70,000	$70,000	$10.80	$1.80
$71,000	$71,000	$71,000	$10.98	$1.80
$72,000	$72,000	$72,000	$11.16	$1.80
$73,000	$73,000	$73,000	$11.84	$1.80
$74,000	$74,000	$74,000	$11.52	$1.80
$75,000	$75,000	$75,000	$11.70	$1.80
$76,000	$76,000	$76,000	$11.88	$1.80
$77,000	$77,000	$77,000	$12.06	$1.80
$78,000	$78,000	$78,000	$12.24	$1.80
$79,000	$79,000	$79,000	$12.42	$1.80
$80,000	$80,000	$80,000	$12.60	$1.80
$81,000	$81,000	$81,000	$12.78	$1.80
$82,000	$82,000	$82,000	$12.96	$1.80
$83,000	$83,000	$83,000	$13.14	$1.80
$84,000	$84,000	$84,000	$13.32	$1.80
$85,000	$85,000	$85,000	$13.50	$1.80
$86,000	$86,000	$86,000	$13.68	$1.80
$87,000	$87,000	$87,000	$13.86	$1.80
$88,000	$88,000	$88,000	$14.04	$1.80
$89,000	$89,000	$89,000	$14.22	$1.80
$90,000	$90,000	$90,000	$14.40	$1.80
$91,000	$91,000	$91,000	$14.58	$1.80
$92,000	$92,000	$92,000	$14.76	$1.80
$93,000	$93,000	$93,000	$14.94	$1.80
$94,000	$94,000	$94,000	$15.12	$1.80
$95,000	$95,000	$95,000	$15.30	$1.80
$96,000	$96,000	$96,000	$15.49	$1.80
$97,000	$97,000	$97,000	$15.66	$1.80
$98,000	$98,000	$98,000	$15.84	$1.80
$99,000	$99,000	$99,000	$16.02	$1.80
$100,000	$100,000	$100,000	$16.20	$1.80
$101,000	$101,000	$101,000	$16.38	$1.80
$102,000	$102,000	$102,000	$16.56	$1.80
$103,000	$103,000	$103,000	$16.74	$1.80
$104,000	$104,000	$104,000	$16.92	$1.80
$105,000	$105,000	$105,000	$17.10	$1.80
$106,000	$106,000	$106,000	$17.28	$1.80
$107,000	$107,000	$107,000	$17.46	$1.80
$108,000	$108,000	$108,000	$17.64	$1.80
$109,000	$109,000	$109,000	$17.82	$1.80
$110,000	$110,000	$110,000	$18.00	$1.80
$111,000	$111,000	$111,000	$18.18	$1.80
$112,000	$112,000	$112,000	$18.36	$1.80
$113,000	$113,000	$113,000	$18.54	$1.80
$114,000	$114,000	$114,000	$18.72	$1.80
$115,000	$115,000	$115,000	$18.90	$1.80
$116,000	$116,000	$116,000	$19.08	$1.80
$117,000	$117,000	$117,000	$19.26	$1.80
$118,000	$118,000	$118,000	$19.44	$1.80
$119,000	$119,000	$119,000	$19.62	$1.80
$120,000	$120,000	$120,000	$19.80	$1.80
$121,000	$121,000	$121,000	$19.98	$1.80
$122,000	$122,000	$122,000	$20.16	$1.80
$123,000	$123,000	$123,000	$20.34	$1.80
$124,000	$124,000	$124,000	$20.52	$1.80
$125,000	$125,000	$125,000	$20.70	$1.80
$126,000	$126,000	$126,000	$20.88	$1.80
$127,000	$127,000	$127,000	$21.06	$1.80
$128,000	$128,000	$128,000	$21.24	$1.80
$129,000	$129,000	$129,000	$21.42	$1.80
$130,000	$130,000	$130,000	$21.60	$1.80
$131,000	$131,000	$131,000	$21.78	$1.80
$132,000	$132,000	$132,000	$21.96	$1.80

LIFE INSURANCE RATE SCHEDULE
09/01/2009 - 08/31/2010 *(cont'd)*

Basic Life and Accidental Death and Dismemberment Costs *(cont'd)*

ANNUAL SALARY ROUNDED UP TO NEXT $1,000	LIFE BENEFIT	AD&D BENEFIT	YOU PAY	THE CITY PAYS
$133,000	$133,000	$133,000	$22.14	$1.80
$134,000	$134,000	$134,000	$22.32	$1.80
$135,000	$135,000	$135,000	$22.50	$1.80
$136,000	$136,000	$136,000	$22.68	$1.80
$137,000	$137,000	$137,000	$22.86	$1.80
$138,000	$138,000	$138,000	$23.04	$1.80
$139,000	$139,000	$139,000	$23.22	$1.80
$140,000	$140,000	$140,000	$23.40	$1.80
$141,000	$141,000	$141,000	$23.58	$1.80
$142,000	$142,000	$142,000	$23.76	$1.80
$143,000	$143,000	$143,000	$23.94	$1.80
$144,000	$144,000	$144,000	$24.12	$1.80
$145,000	$145,000	$145,000	$24.30	$1.80
$146,000	$146,000	$146,000	$24.48	$1.80
$147,000	$147,000	$147,000	$24.66	$1.80
$148,000	$148,000	$148,000	$24.84	$1.80
$149,000	$149,000	$149,000	$25.02	$1.80
$150,000	$150,000	$150,000	$25.20	$1.80
$151,000	$151,000	$151,000	$25.38	$1.80
$152,000	$152,000	$152,000	$25.56	$1.80
$153,000	$153,000	$153,000	$25.74	$1.80
$154,000	$154,000	$154,000	$25.92	$1.80
$155,000	$155,000	$155,000	$26.10	$1.80
$156,000	$156,000	$156,000	$26.28	$1.80
$157,000	$157,000	$157,000	$26.46	$1.80
$158,000	$158,000	$158,000	$26.64	$1.80
$159,000	$159,000	$159,000	$26.82	$1.80
$160,000	$160,000	$160,000	$27.00	$1.80
$161,000	$161,000	$161,000	$27.18	$1.80
$162,000	$162,000	$162,000	$27.36	$1.80
$163,000	$163,000	$163,000	$27.54	$1.80
$164,000	$164,000	$164,000	$27.72	$1.80
$165,000	$165,000	$165,000	$27.90	$1.80
$166,000	$166,000	$166,000	$28.08	$1.80
$167,000	$167,000	$167,000	$28.26	$1.80
$168,000	$168,000	$168,000	$28.44	$1.80
$169,000	$169,000	$169,000	$28.62	$1.80
$170,000	$170,000	$170,000	$28.80	$1.80
$171,000	$171,000	$171,000	$28.98	$1.80
$172,000	$172,000	$172,000	$29.16	$1.80
$173,000	$173,000	$173,000	$29.34	$1.80
$174,000	$174,000	$174,000	$29.52	$1.80
$175,000	$175,000	$175,000	$29.70	$1.80
$176,000	$176,000	$176,000	$29.88	$1.80
$177,000	$177,000	$177,000	$30.06	$1.80
$178,000	$178,000	$178,000	$30.24	$1.80
$179,000	$179,000	$179,000	$30.42	$1.80
$180,000	$180,000	$180,000	$30.60	$1.80
$181,000	$181,000	$181,000	$30.78	$1.80
$182,000	$182,000	$182,000	$30.96	$1.80
$183,000	$183,000	$183,000	$31.14	$1.80
$184,000	$184,000	$184,000	$31.32	$1.80
$185,000	$185,000	$185,000	$31.50	$1.80
$186,000	$186,000	$186,000	$31.68	$1.80
$187,000	$187,000	$187,000	$31.86	$1.80
$188,000	$188,000	$188,000	$32.04	$1.80
$189,000	$189,000	$189,000	$32.22	$1.80
$190,000	$190,000	$190,000	$32.40	$1.80
$191,000	$191,000	$191,000	$32.58	$1.80
$192,000	$192,000	$192,000	$32.76	$1.80
$193,000	$193,000	$193,000	$32.94	$1.80
$194,000	$194,000	$194,000	$33.12	$1.80
$195,000	$195,000	$195,000	$33.30	$1.80
$196,000	$196,000	$196,000	$33.48	$1.80
$197,000	$197,000	$197,000	$33.66	$1.80
$198,000	$198,000	$198,000	$33.84	$1.80
$199,000	$199,000	$199,000	$34.02	$1.80
$200,000	$200,000	$200,000	$34.20	$1.80
$201,000	$201,000	$201,000	$34.38	$1.80
$202,000	$202,000	$202,000	$34.56	$1.80
$203,000	$203,000	$203,000	$34.74	$1.80
$204,000	$204,000	$204,000	$34.92	$1.80
$205,000	$205,000	$205,000	$35.10	$1.80
$206,000	$206,000	$206,000	$35.28	$1.80
$207,000	$207,000	$207,000	$35.46	$1.80
$208,000	$208,000	$208,000	$35.64	$1.80
$209,000	$209,000	$209,000	$35.82	$1.80
$210,000	$210,000	$210,000	$36.00	$1.80
$211,000	$211,000	$211,000	$36.18	$1.80
$212,000	$212,000	$212,000	$36.36	$1.80
$213,000	$213,000	$213,000	$36.54	$1.80
$214,000	$214,000	$214,000	$36.72	$1.80
$215,000	$215,000	$215,000	$36.90	$1.80
$216,000	$216,000	$216,000	$37.08	$1.80
$217,000	$217,000	$217,000	$37.26	$1.80
$218,000	$218,000	$218,000	$37.44	$1.80
$219,000	$219,000	$219,000	$37.62	$1.80
$220,000	$220,000	$220,000	$37.80	$1.80
$221,000	$221,000	$221,000	$37.98	$1.80
$222,000	$222,000	$222,000	$38.16	$1.80
$223,000	$223,000	$223,000	$38.34	$1.80
$224,000	$224,000	$224,000	$38.52	$1.80
$225,000	$225,000	$225,000	$38.70	$1.80
$226,000	$226,000	$226,000	$38.88	$1.80
$227,000	$227,000	$227,000	$39.06	$1.80
$228,000	$228,000	$228,000	$39.24	$1.80
$229,000	$229,000	$229,000	$39.42	$1.80
$230,000	$230,000	$230,000	$39.60	$1.80
$231,000	$231,000	$231,000	$39.78	$1.80
$232,000	$232,000	$232,000	$39.96	$1.80
$233,000	$233,000	$233,000	$40.14	$1.80
$234,000	$234,000	$234,000	$40.32	$1.80
$235,000	$235,000	$235,000	$40.50	$1.80
$236,000	$236,000	$236,000	$40.68	$1.80
$237,000	$237,000	$237,000	$40.86	$1.80
$238,000	$238,000	$238,000	$41.04	$1.80
$239,000	$239,000	$239,000	$41.22	$1.80
$240,000	$240,000	$240,000	$41.40	$1.80
$241,000	$241,000	$241,000	$41.58	$1.80
$242,000	$242,000	$242,000	$41.76	$1.80
$243,000	$243,000	$243,000	$41.94	$1.80
$244,000	$244,000	$244,000	$42.12	$1.80
$245,000	$245,000	$245,000	$42.30	$1.80
$246,000	$246,000	$246,000	$42.48	$1.80
$247,000	$247,000	$247,000	$42.66	$1.80
$248,000	$248,000	$248,000	$42.84	$1.80
$249,000	$249,000	$249,000	$43.02	$1.80
$250,000	$250,000	$250,000	$43.20	$1.80

SUPPLEMENTAL FLEXIBLE BENEFITS PLAN

The City of Atlanta is pleased to sponsor the Supplemental Flexible Benefits Plan so you can use your pre-tax dollars to pay for several different insurance and benefits programs according to your specific needs.

Section 125 of the Internal Revenue Code currently allows you, thru payroll deduction, to elect up to $5,000 per plan year for dependent care reimbursement and up to $2,500 for unreimbursed medical expenses.

You may also participate in the following supplemental insurance plans (information will follow in a separate booklet):

CANCER COVERAGE

•

HOSPITAL INTENSIVE CARE

•

HOSPITAL INDEMNITY

•

ACCIDENTAL/DISABILITY

•

PERSONAL SHORT-TERM DISABILITY

Details regarding benefits amounts and premium schedules are provided to you by American Family Life Assurance Company (Aflac), a co-administrator of the Plan.

All elected officials, appointed officials, all full-time and part-time permanent employees are eligible to participate in the program from date of hire. The choices you make are for the full plan year.

You may also enroll during Open enrollment by completing the Supplemental Flexible Benefits Inquiry forms. Mail the form to Aflac, postage free.

Flexible Spending Accounts, dependent care reimbursement and unreimbursed medical expense you elected for 2009 will terminate June 30, 2009. ***The plan year will change to 09/01/2009 through 08/31/2010. You must re-enroll each year.*** *Applications for both new participants and renewals must be completed by July 22, 2009.*

Supplemental Insurance Plans you elected in 2009 will continue for 2010. Premium rates remain the same as in 2009. Payroll deduction will continue unless you request the change or terminate coverage. Changes and terminations can only be made during Open Enrollment.

All claims must be filed within 90 days of the end of the plan year.

SUPPLEMENTAL FLEXIBLE BENEFITS INQUIRY FORM

Yes, I would like information on plans available thru Aflac.

Flexible Spending Accounts

You must complete a new application for 09/01/2009 – 08/31/2010.

❑ **Dependent Care**
Allows you to pre-tax cost of dependent care expenses. The amount of child or dependent care expenses reimbursed cannot be more than $5,000 per contract year.

❑ **Unreimbursed Medical Expenses**
Allows you to pre-tax cost of unreimbursed medical expenses not covered by City of Atlanta health coverages. The amount of reimbursed medical expenses can not be more than $5,000 per calender year. (i.e., example contact lenses).

The amount of money you save in taxes depends in part on your dependent care and unreimbursed medical elections. Care must be taken when making those estimates. After expenses are estimated and elections are made, money will be held on account to pay those cost. Under the "Use It or Lose It" rule, any monies taken pre-tax must be used to pay for qualified elected benefits or they will be forfeited to the employer.

SUPPLEMENTAL INSURANCE – Aflac COVERAGE

(Coverage will continue in 2009 - 2010 unless changed or terminated.)

❑ **Cancer Coverage**
Pays directly to you, does not coordinate with health coverage, helps cover out-of-pocket expenses and deductibles related to cost of cancer treatment.

❑ **Hospital Intensive Care**
Pays directly to you, does not coordinate with health coverages, pays for confinement in intensive care, coronary care or neonatal care units.

❑ **Hospital Indemnity**
Pays benefits directly to you to help with hospital bills and out-of-pocket costs.

❑ **Accident/Disability**
Pays cash directly to you for off the job accidents and disability coverage.

❑ **Personal Short-Term Disability**
Pays cash directly to you for accident and sickness disability.

❑ **I would like to make changes in my current Aflac coverages.**
Please call your Aflac representative or **(770) 449-5215**.

❑ **I would like to terminate my current Aflac coverage.**
Please call your Aflac representative or **(770) 449-5215**.

Yes, I would like information on plans available thru payroll deduction.

❑ Dependent Child Care
❑ Unreimbursed Medical Expenses
❑ Cancer Coverage
❑ Hospital Intensive Care
❑ Accident/Disability
❑ Personal Short-Term Disability
❑ Hospital Indemnity
❑ I would like to make changes in my current Aflac coverage.

Please Contact Me:

Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Best time to contact me _____

Department _____

*Please call Aflac for complete details at **(770) 449-5215***

DETACH THIS FORM ALONG PERFORATED LINE AND MAIL TO
AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS, GA (Aflac).

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST CLASS MAIL PERMIT NO. 523-533 DORAVILLE, GEORGIA

POSTAGE WILL BE PAID BY ADDRESSEE

Aflac
P.O. BOX 47903
DORAVILLE, GEORGIA 30362-9915

DEFERRED COMPENSATION PLANS

You have an opportunity to participate in the City of Atlanta Deferred Compensation Plan (in accordance with Section 457 of the Internal Revenue Code), especially valuable to your overall financial planning for retirement. **Please note – this plan is not a savings account.**

The primary purpose of a Deferred Compensation Plan is to allow you to set aside a portion of your salary and receive its value when you retire. The amount of current earnings deferred will not be considered as income for tax purposes until its value is paid, as provided in the Plan. At that time, it will be taxable as ordinary income.

By deferring payment of income taxes until you receive the value of your account as a retirement benefit, you can set aside more of your current earnings for retirement. Therefore, you may reduce the total amount of income taxes paid in your lifetime and accumulate a larger sum for retirement under the Plan than if you had invested after-tax dollars outside the Plan.

You may stop your contributions at any time. If you wish to increase the amount of your deferral, you may do so subject to the legal maximum at any time. If necessary, you may increase, decrease or reinstate your deferral amount at any time. If you want to make deduction changes, contact the Department of Finance – Payroll Division or the company with whom you are participating.

Your account will begin earning investment income on the date your deferral is deposited into your account with the provider.

A distribution of all or portion of your Deferred Compensation Account is permitted in the event you experience an Unforeseeable Financial Hardship, as defined by the IRS, which is beyond your control. Evidence is required, to be sent with written request. For details, call DHR Insurance Division at (404) 330-6036

Note: Deferred Compensation does not affect your City Retirement or Social Security. For federal tax purposes, your W-2 will only reflect your adjusted gross income.

You should investigate the Plan if you: currently save on a regular basis; you are paying a substantial amount of tax; your family has two or more incomes; or if you are approaching retirement.

If you make the election to participate in the City of Atlanta's Deferred Compensation Plan, please contact the Local Representative or the provider of your choice listed below:

- **ING Life Insurance and Annuity Company**
  Customer Service – (800) 525-4225
- **ICMA-RC**
  Customer Service – (800) 669-7400
- **Nationwide Retirement Corporation**
  Customer Service – (877) 677-3678

All employees are eligible to participate. The Plan is entirely voluntary.

Employees Contemplating retirement should note Ordinance 08-0-1024 adopted by Council June 19, 2008 and approved by the Mayor June 24, 2008 which State in relevant parts:

Section1: Effective September 1, 2008, The City will require Medicare eligible retirees, their spouses and dependents to obtain both part A and B of Medicare at the time of eligibility in order to receive City of Atlanta retiree benefits. Medicare eligible retirees will be offered a group Medicare Advantage Plan or similar benefits plan. Employees hired before April 1, 1986 who are not Medicare eligible will receive the same benefit plan as offered active employees.

Section 2: Effective September 1, 2008, the City of Atlanta contribution rate for retiree health insurance of retirees hired before April 1, 1986, who are not Medicare eligible will be the same as the City contribution rate for active employees. The City contribution rate for retiree health insurance for Medicare eligible retirees will be as follows:

Retirement on or before August 31, 2009 City Contribution -70%
Retirement between September 1, 2009 and before August 31, 2010 City Contribution -60%
Retirement after August 31, 2010 City Contribution -50%.

At no time the City contribution rate for retiree health insurance exceed the contribution rate for active employees. In such instance, the contribution rate defaults to the same rate as active employees.

Section 3: The city of Atlanta will continue to make the same contribution for retiree dental insurance that is made for active employee.

Section 4: that all ordinances and parts of ordinances in conflict herewith be and the same are hereby waved.

All Medicare eligible retirees and/or spouses must enroll in both Part A and B and are then eligible for BCBS SmartValue or Kaiser Permanente Senior Advantage.

If you and/or your spouses are eligible for Medicare, and not currently enrolled in part A and B, to continue coverage in a City of Atlanta Plan, you must enroll in Part A and B when eligible (at age 65, within 8 months of retirement, or at the next Medicare General Enrollment Period, 10/01/2010 - 03/31/2010). At the time your coverage in Part A and B begins, you must change your enrollment to a Medicare Advantage Plan.

Helpful Contact Information:

Social Security:	**1-800-772-1213**
	www.socialsecurity.gov
Medicare:	**1-800-633-4227**
	www.medicare.gov

Please check the blue pages in your telephone book for the Social Security office nearest to your resident.

IMPORTANT POINTS TO REMEMBER

To ensure you receive timely and appropriate benefits, be certain that your current address is on file with your department and with the Department of Human Resources. If your address is incorrect, complete an EMPLOYEE CHANGE OF ADDRESS NOTIFICATION FORM – you must submit it to your department representative. Do not submit changes to DHR Insurance Division as we cannot make address changes.

City of Atlanta

Employee Personal Data Change (EPDC) Form

☐ Name change ☐ DOB _____
☐ Address change ☐ Marital status change
☐ Contact number ☐ EEOC Data
☐ Emergency contact data ☐ Citizenship status

Employee ID number	Employee name (Last, First, Middle)	SSN
Department		DOB

Name Change

Former name	New name (must have updated Social Security card to change)

Address Change

Address			Apt #
City	County	State	Zip
Home Phone Number	Work Phone Number	Cell Phone Number	

Note: If mailing address is different from home address, complete information below.

Mailing address			Apt #
City	County	State	Zip

EEOC Data

Gender ☐ M ☐ F	Race ☐ White ☐ Black/ African American ☐ Hispanic/ Latino ☐ Asian ☐ American Indian or Alaskan Native ☐ Native Hawaiian or Pacific Islander ☐ Two or more races	
Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Marital status date	Date of divorce

Emergency Contact Data

Name	Relationship	Phone
Address		Apt #
City	State	Zip code

Citizenship Status

☐ US citizen ☐ Lawful perm. resident (Alien #) A _____ ☐ Naturalized _____
☐ Alien auth. to work until _____ (Alien # or Admission #) _____

Employee Acknowledgement

I certify that the above information is correct and I understand that I am required to maintain this information on a current basis with the Department of Human Resources in accordance with the Civil Service Rules and Regulations of the City of Atlanta.

Employee's Signature	Title	Date

Forward Original to Department of Human Resources

Name of DHR staff entering the data	Date

DHR 3/2007 Employee Personal Data Change Form FORM 101

CONTINUATION OF COVERAGE NOTICE

Under COBRA – the Consolidated Omnibus Reconciliation Act of 1985, Title X, terminated employees and their eligible dependents may continue group health plan coverage. We urge you to read this description of the "continuation coverage" option carefully, and to make sure you and your spouse read and understand the rights and responsibilities in connection with this continuation of coverage. Both you and your spouse must sign the front page of this enrollment application.

The American Recovery and Reinvestment Act of 2009 (ARRA), the financial stimulus law signed by President Barack Obama on February 17, 2009, includes significant changes to the COBRA continuation coverage rules. In general, the ARRA:

- Provides a 65 percent federal government subsidy of COBRA continuation coverage premiums for a maximum of nine months for certain individuals who are COBRA qualified beneficiaries because of a covered employee's involuntary termination of employment on or after September 1, 2008 and on or before December 31, 2009.
- Requires employers to pay the 65 percent portion upfront, and then allows them to deduct those costs from their Social Security and Medicare taxes **(see Claiming the New COBRA Premium Credit on Payroll Tax Forms)**.
- Retroactively allows workers who became jobless as early as September 1, 2008, and rejected COBRA coverage to reconsider and receive COBRA benefits.

The Benefits

If you are currently covered under The City of Atlanta Health Plan, you will be entitled to continue your and your family's Health Plan coverage for up to 18 months from the date coverage would have terminated because of voluntary or involuntary termination. If a qualified beneficiary is deemed disabled for Social Security, at the date of the qualifying event, or within the first 60 days following the qualifying event, the continuation coverage period is 29 months for all the members of your family who have elected COBRA. The 18-month period may be extended also if other events (such as a death or divorce) occur during that 18-month period. Employees discharged because of "gross misconduct" would not be eligible for continuation of coverage. Dependents who no longer qualify as dependents under the City of Atlanta Health Plan are eligible to apply for continuation of coverage. If you should die or become divorced, and if your spouse and dependents are covered by the City of Atlanta Health Plan at that time, they will be entitled to continue health coverage for up to 36 months. Continuation coverage is also available for your children for up to 36 months if they get married, leave your household, attain age 19, or age 26 if they are full-time students and they are not covered under another group health plan that duplicates coverage. If an Eligible Person is 60 years old on the date COBRA continuation coverage started COBRA coverage may extend up to the time of Medicare eligibility. If you have a new born child, adopt a child or have a child placed in your home pending adoption (for whom you have financial responsibility), while your COBRA continuation is in effect, you may add this child to your coverage.

The Cost

Continuation of coverage is optional on the part of the employee or dependent. Those who elect continuation of coverage will be required to pay 102% of the total monthly group premium for the applicable class of coverage. For the extended disability coverage, employees may be required to pay up to 150% of the monthly group premium for coverage during the 19th through the 29th month. Persons 60 years old on the date of COBRA eligibility may be required to pay up to 120% of the premium for extended time. There will be no contribution made by the City of Atlanta. Premiums are due monthly and in advance. You should note that your continuation coverage will stop if the premiums for this coverage are not paid on time.

If you elect to continue coverage new dependents may be added during the period of continuation on the same basis as they are added for active employees. If during continuation of coverage, health benefits and premium rates change, your coverage and costs will be affected accordingly. Should open enrollment occur during the period of your continuation you will retain your right to switch to a different option.

When Coverage Ends

If you or covered members of your family become entitled to Medicare or are covered under another employer-sponsored health plan, which does not limit coverage due to preexisting conditions, the continuation coverage from the City of Atlanta Health Plan will cease. In addition, your coverage will cease if City of Atlanta should terminate the Health Plan or you cease to pay premium. Once the period of coverage continuation has expired, anyone receiving continuation coverage will be eligible to convert to individual policies, as provided under the City of Atlanta Plan.

What You Must Do

You or your spouse or dependents must notify the DHR Insurance Division when your dependent child marries, reaches the maximum age under the Plan, ceases to be a full-time student (if between the ages of 19 and 26), or in the event you become divorced. It is important that you notify us of your or your dependents loss of Plan eligibility promptly–in advance, if possible, but no later than 60 days from the date coverage would otherwise have terminated in order to be eligible to elect continuation coverage. Within 14 days after the end of the month in which you notified the DHR Insurance Division, you or your eligible dependents will be mailed information and forms regarding continuation of coverage. You or your dependent must return the completed election forms within 60 days. If continuation of coverage is selected within 60 days you or your dependent will then have an additional 45 days to pay the applicable premium, retroactive to the date coverage would otherwise have terminated.

If you would like further information on continuation coverage under the City of Atlanta Health Plan, please contact the DHR Insurance Division at **(404) 330-6036**.

Conversion Privilege

When your group health insurance ends due to termination of employment with the City of Atlanta or due to expiration of COBRA continuation of health care coverage under the group contract you may apply for converted health coverage. For additional information contact the DHR Insurance Division at **(404) 330-6036**.

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA), better known as the KASSEBAUM-KENNEDY LEGISLATION.

If you terminate your employment with the City, or your COBRA eligibility terminates, A CERTIFICATE OF GROUP HEALTH PLAN COVERAGE will be mailed by your Insurance Carrier/HMO, to the last address on their file.

If you are a new employee, have previously waived your health insurance, or are adding a dependent other than a new born (or child placed in your home pending adoption), you should provide copies of the CERTIFICATE OF GROUP HEALTH PLAN COVERAGE issued to you or your dependents, by the previous employer(s) for CREDITABLE PRIOR COVERAGE pre-existing condition exclusions, if any.

GLOSSARY

Application: A signed statement of facts requested by the company on the basis of which the company decides whether or not to issue a policy. This then becomes part of the health insurance contract when the policy is issued.

Approved Amount: The amount determined by the Medicare carrier to be reasonable and fair for each service.

Beneficiary: The person designated or provided for by the terms to receive the proceeds upon the death of the insured.

Benefit Package: A collection of specific services or benefits that the HMO and Indemnity is obligated to provide under terms of its contracts with subscriber groups or individuals.

Benefit Period: The period of time during which benefits are available, such as a year or for the lifetime of the contract.

Benefits: The amount payable by an insurance company for covered services.

Carrier: The insurance company responsible for processing claims; it may perform the carrier function on its own behalf, or for another entity who pays losses; under the Medicare program, for example, the Social Security Administration selects private insurance companies to administer Part B claims.

Claim: A demand to the insurer for the payment of benefits under the insurance contract.

Coinsurance: The fixed percentage of covered charges you must pay after any deductible has been subtracted. For example, if a plan pays 80 percent of covered charges (after applying any deductible), you would be responsible for the deductible and the 20 percent balance.

Consumer Choice Option (CCO): A health plan mandated in 1999 by the Georgia General Assembly. This plan allows members to nominate a non-network provider that will act as a part of the network. An employee who has selected the CCO may elect a qualified provider to render any covered services. Member is subject to normal rules and conditions that apply to a contracted network provider, i.e., reimbursement, usual customary and reasonable costs, and prescription drugs. Members will incur additional costs if they choose the CCO health plan.

Contingent Beneficiary: Person named to receive proceeds or benefits should an unforeseen event prevent the named Primary Beneficiary(ies) from collecting benefits(or insurance).

Conversion Privilege: A privilege granted in an insurance policy to convert to a different plan of insurance without providing evidence of insurability. The privilege granted by a group policy is to convert to an individual policy upon termination of group coverage.

Coordination of Benefits: Establishes procedures to be followed in the event of duplicate coverage thus assuring that no more than 100 percent of the costs of care are reimbursed to the patient.

Copayment: A fixed dollar amount you must pay for a service or benefit provided by a plan.

Coverage: The amount or extent to which any particular treatment or service is insured by a health provider.

Deductible: The amount of covered charges you must pay before the plan pays benefits, for example, calendar-year deductible and inpatient hospital deductible. Generally, no more than two or three family members must meet the calendar-year deductible. However, some plans have a family calendar-year deductible, which can be met by any or all of those covered.

Dental Care: Coverage may include routine diagnostic and preventive services and one or more of the following treatment services: restorative, crown and bridge, endodontic, oral surgery, periodontal, prosthetic, and orthodontic. Some prepaid plans (DMOs) limit coverage to preventive services for children.

Disability: A limitation of physical or mental functional capacity resulting from sickness or injury. It may be partial or total. (See also Partial Disability and Total Disability.)

Domestic Partnership: A union in which two individuals (unrelated by blood) of the opposite or same sex choose to share their lives in a close and committed relationship of mutual caring; who live together and have signed a ***Declaration of Domestic Partnership*** in which they have agreed to be jointly responsible for basic living expenses incurred during the Domestic Partnership.

Effective Date: The date on which the insurance under a policy begins.

Eligibility Period: A specified length of time, frequently 30 days following the eligibility date during which an individual member of a particular group will remain eligible to apply for insurance under a group life or health insurance policy without evidence or insurability.

Eligible Date: The date on which an individual member of a specified group becomes eligible to apply for insurance under the (group life or health) insurance plan.

Eligible Employees: Those members of a group who have met the eligibility requirements under a group life or health insurance plan.

Evidence of Insurability: Any statement of proof of a person's physical condition and/or other factual information affecting his/her acceptance for insurance.

Exclusions: Charges, services, or supplies that are not covered. A plan does not provide or pay for excluded items, nor do charges for them apply toward deductibles and catastrophic limits.

Flexible Spending Account (FSA): A benefit option that reimburses employees for certain expenses they incur. Money is deducted from pay checks on a pre-tax basis. It most often covers reimbursements for medical expenses not covered under other insurance, or child care expenses.

Grace Period: A specified period – thirty-one days – after a premium payment is due, in which the policyholder may make such payment, and during which the protection of the policy continues.

HCFA: Health Care Financing Administration. The agency of the U.S. Department of Health and Human Services that is responsible for administering the Medicare and Medicaid programs.

HIPAA: Health Insurance Portability and Accountability Act of 1996. A federal law which requires employers to provide certificates of coverage to minimize pre-existing condition exclusions.

Health Insurance: Protection that provides payment of benefits for covered sickness or injury. Included under this heading are various types of insurance such as accident insurance, disability income insurance, medical expense insurance, and accidental death and dismemberment insurance.

Health Maintenance Organization (HMO): An organization that provides a wide range of health-care services for a specified group at a fixed periodic payment. The HMO can be sponsored by the government, medical schools, hospitals, employers, labor unions, consumer groups, insurance companies, and hospital-medical plans.

Hospice Care: A coordinated program at home and/or on an inpatient basis, offering easing of the patient's pain and discomfort, and providing supportive care, for a terminally ill patient and the patient's family, provided by a medically supervised specialized team under the direction of a licensed or certified hospice-care facility or agency.

GLOSSARY *(cont'd)*

In-Network Provider: Selected physicians who furnish a comprehensive array of healthcare services. Under contractual agreement, doctors accept the insurance carriers "Usual, Customary and Reasonable" amounts, as payment-in-full.

Inpatient Services: The care provided while a bed patient is in a covered facility. Provides extra benefits for services not covered at all by the base plan, and that in some cases pays balances of services not covered completely by the base plan; most are characterized by large benefit maximums, ranging from $250,000 to no limit; above an initial deductible, major medical reimburse the major percentage of all charges for hospital, doctor, private nurses, and so on; the policyholder insurer pays the remaining co-insurance.

Managed Care: Health-care systems that integrate the financing and delivery of appropriate health-care services to covered individuals by arrangements with selected providers to furnish a comprehensive set of health-care services, explicit standards for selection of health-care providers, formal programs for ongoing quality assurance and utilization review and significant financial incentives for members to use providers and procedures associated with the plan.

Medicaid: State programs of public assistance to people, regardless of their age, whose income and resources are insufficient to pay for health care. Title 19 of the federal Social Security Act provides matching federal funds for financing state Medicaid programs, effective January 1, 1966.

Medicare Supplements (Medigap): Policies sold by insurance companies that help supplement the amounts not paid by the Medicare program for covered services.

Medicare: The government health insurance system for people over the age of 65 (and for certain other groups), created by the 1965 amendments to the Social Security Act. This includes coverage for prescription drugs under Medicare Part D.

Miscellaneous Expenses (Ancillary Charges): Hospital charges (other than room and board) such as for x-rays, drugs, and laboratory fees.

Open Enrollment Period: The period of time stipulated in a group contract in which eligible of the group can choose a health plan alternative for the coming benefit year.

Out-of-Area Benefits: The scope of emergency benefits (and related limitations) available to HMO members while temporarily outside their defined service areas. Some HMOs offer unlimited out-of-area emergency coverage. Others impose a stated maximum annual dollar benefit. Emergency coverage is usually the only HMO benefit in the total benefit package for which members may need to file claim forms for reimbursement of their out-of-pocket expenditures for care.

Out-of-Network Providers: Physicians who do not participate in a contractual relationship, that provide services and care for a predetermined amount to a carrier's member.

Outpatient Services: The care provided to you in the outpatient department of a hospital, in a clinic or other medical facility, or in a doctor's office.

Partial Disability: The result of an illness or injury that prevents an insured from performing one or more of the functions of his or her regular job.

Participating Physician: A doctor or supplier who agrees to accept Medicare assignment on all claims under the medicare program. Agreement by which, under the contractual agreement, the doctors accept the insurance carriers usual, customary, and reasonable amount as payment in full.

Point-of-Service (POS): This product may also be called an open-ended HMO and offers a transition product incorporating features of both HMOs and PPOs. Beneficiaries are enrolled in an HMO but have the option to go outside the network for an additional cost.

Preadmission Certification: A procedure whereby (1) you or your doctor is required to contact your plan before your admission to a hospital, and (2) your plan determines the appropriateness of the admission and the length of stay by using established medical criteria.

Preexisting Condition: A physical and/or mental condition of an insured that first manifested itself prior to the issuance of his or her policy or that existed prior to issuance and for which treatment was received.

Preferred Provider Organization (PPO): A group of physicians and/or hospitals who contract with an employer to provide services to their employees. In a PPO the patient may go to the physician of his/her choice, even if that physician does not participate in the PPO, but the patient receives care at a lower benefit level.

Premium: The fee you must pay (monthly, biweekly, quarterly) on a regular basis for your enrollment in a plan.

Prescription Drugs: Outpatient drugs and medicines which, by United States law, cannot be obtained without a doctor's prescription.

Primary Care Network: The structure for these networks will vary considerably depending on the specific network. It may range from a loose association of physicians in a geographic area with a limited sharing of overhead, patient referral, call, etc. to a more structured association with commonly owned satellite clinics, etc.

Primary Care Physician (PCP): Provide treatment of routine injuries and illness and focuses on preventative care. Serves as gatekeeper for managed care. The American Academy of Family Practice defines primary care as "care from doctors trained to handle health concerns not limited by problem origin, organ systems, gender or diagnosis.

Prior Authorization: Procedure used in managed care to control utilization of services by prospective reviewing and approval.

Providers: Those institutions and individuals who are licensed to provide health care services (for example, hospitals, skilled nursing facilities, physicians, pharmacists, etc.). Providers in a defined service area are principally owned by, affiliated with, employed by, or under contract to an HMO.

Service Area: The geographic area where prepaid plan (HMO) providers and facilities are available to you. This area would be the same as, or within, the plan's enrollment area.

Total Disability: An illness or injury that prevents an insured person from continuously performing every duty pertaining to his or her occupation or engaging in any other type of work. (This wording varies among insurance companies.)

UCR (Usual, Customary, and Reasonable): A maximum payment allowed for a given medical service based on a statistical formula calculated by an insurance company to determine the amount it will pay on a given medical service.

Waiting Period: The length of time an insured must wait from his or her date of enrollment or application for coverage to the date his or her insurance is effective.

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